

Building capacities in healthcare

CLAIRVOYANCE '09

Enhancing abilities, mitigating vulnerabilities

SOUVENIR

SCHOOL OF HEALTH SYSTEMS STUDIES
TATA INSTITUTE OF SOCIAL SCIENCES, MUMBAI



Tata Institute of
Social Sciences



C
L
A
I
R
V
O
Y
A
N
C
E

'09

14022

CLIC-
CPHE



Science & Innovation
Network



SOCHARA
Community Health
Library and Information Centre (CLIC)
Centre for Public Health and Equity
No. 27, 1st Floor, 6th Cross, 1st Main,
1st Block, Koramangala, Bengaluru - 34
Tel : 080 - 41280009
email : clic@sochara.org / cphe@sochara.org
www.sochara.org

NESOTA

lth

CLAIRVOYANCE.... *Envisioning Healthcare!*

'**Clairvoyance**' is a signature annual event conducted by the students of School of Health Systems Studies, TISS. It is said that: 'The way of the world is meeting people through other people.' Over the years, the event has drawn participation from healthcare professionals, industry stalwarts and students of top medical, paramedical and management schools across India. It has addressed pertinent issues facing healthcare as it transitioned from 'sector' to 'industry'.

Our logo truly represents the meaning of the word, Clairvoyance – 'An eye which envisions the future of global healthcare and emphasizes the paramount role of India in the global healthcare.'

Clairvoyance '09 is an exploration of innovative ways to build capacities at various levels of healthcare. The overarching theme of this year's Clairvoyance '09 is: "Building Capacities in Healthcare"

FOREWORD

SESSIONS

ARTICLES

POSTER GALLERY

contents

CLAIRVOYANCE 2009 COMMITTEES

Faculty Coordinator

Dr. Hemal Shroff

Students Members

Dr. Amar Nawkar

Dr. Dinesh Jagiasi

Dr. Nachiket Sule

Dr. Omkar Phanse

Dr. Sandhya Sarfare

Dr. Sumegha Sharma

Souvenir Committee

Mr. Lalmangaih Hauzel

Dr. Mohit P. Gandhi

Address

School of Health System Studies

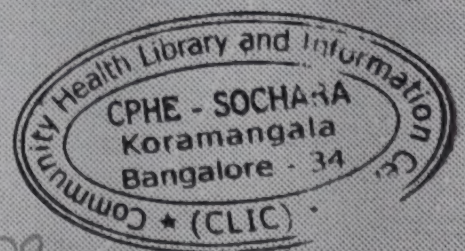
Tata Institute of Social Sciences

VN Purav Marg, Deonar

Mumbai - 400 088

Website

www.shss.tiss.edu



PH-100
14022 P09



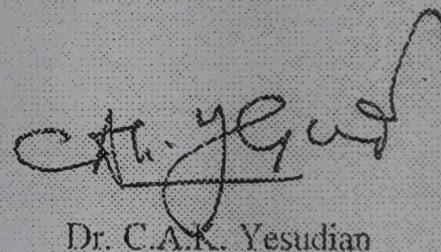
Dr. C.A.K. Yesudian
Dean
School of Health Systems Studies

December 14, 2009

Tata Institute of Social Sciences is involved in offering postgraduate training in healthcare management and public health for the last two decades. Today it offers two management and two public health postgraduate degree programmes. Students and alumni have played a major role in professionalizing healthcare administration and public health all over the country and abroad. Wherever the students have gone, they have made their mark in those organizations. The current batches of students are no exception to this.

I am glad to note that keeping the tradition of the School, the students are organizing the annual event, Clairvoyance - 2009 and the theme of the Conference is "Building Capacities in Health Care: Enhancing Abilities, Mitigating Vulnerabilities". As part of the Conference, the students are bringing out this souvenir to express their knowledge and skills.

I congratulate the students for their effort to bring out this souvenir emphasizing on professionalizing health care management and public health. I wish them all success.



Dr. C.A.K. Yesudian



Day One

(19th December, Saturday): Session 1 (9:00am to 10:30am)

Topic: How to run a health service: trust, mistrust, voice or choice?

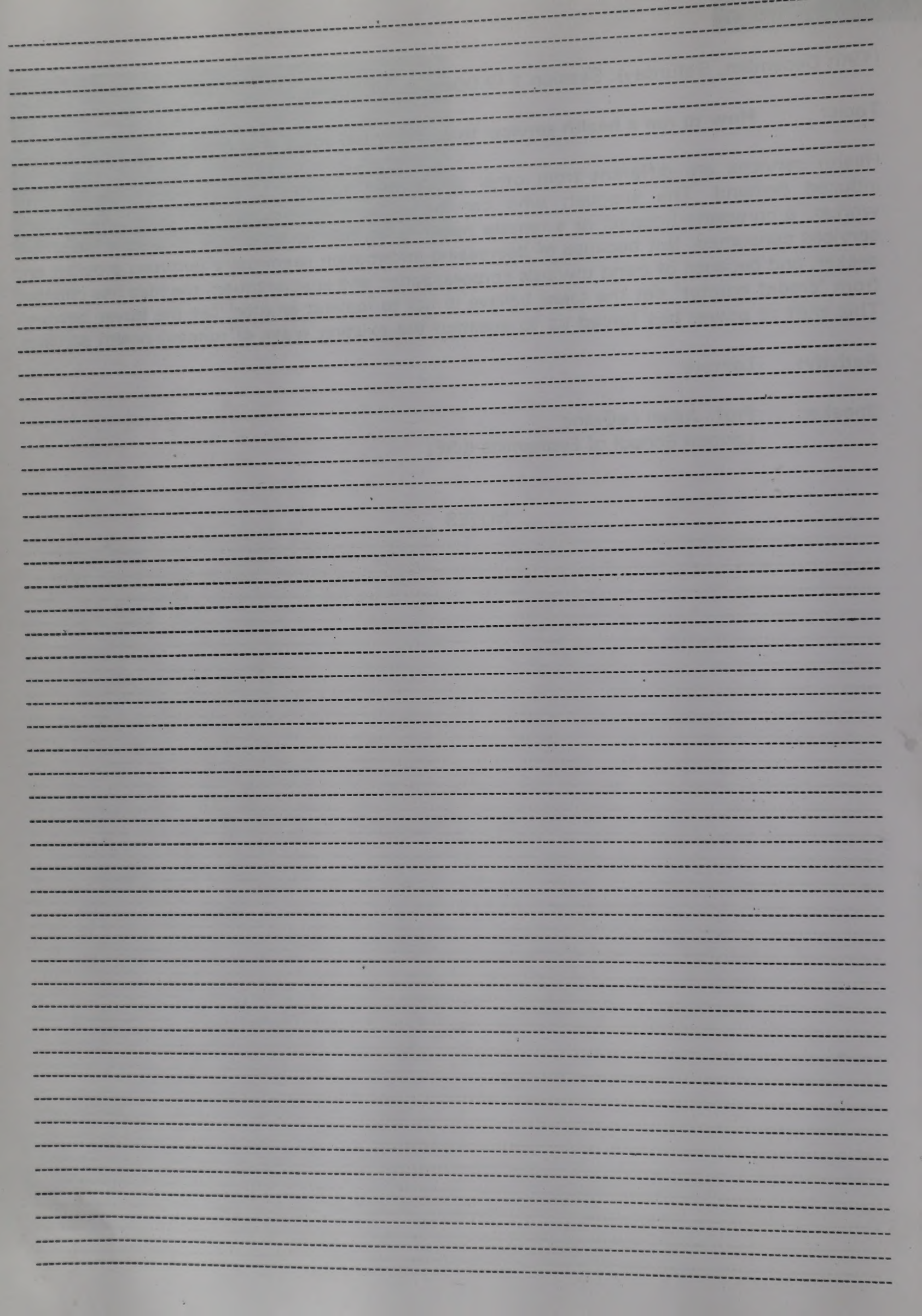
Health services are different from other goods and services in that they have a supply induced demand. The supplier, who can be a super-specialist or a community health worker, a corporate hospital or a remote health post, has to build trust in people to get his services consumed. But because of decreasing information asymmetry between provider and seeker, and because of trend towards corporatization and specialization, the idea has changed from 'credat emptor' (let the taker believe in us) to 'caveat emptor' (let the buyer beware). This shift of power has forced us to question the existing ways of running health services.

Activity: Lecture

Speaker: Prof. Julian LeGrand
London School of Economics (LSE)

NOTES

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.



Day 1(19th December, Saturday): Session 2 (10:45am to 00:15pm)

Topic: Capacity Building at the Grass root levels

Public health is an evolving and dynamic field of action that aims to restore, protect and promote people's mental, physical and social well-being. In contemporary situation the public health service delivery has become complex with a multitude of interventions requiring simultaneous implementation. Following the recent reforms, there is a growing pressure on grass-root workers to manage far more diverse tasks than what they have been trained for. Developing a pool of well-trained, competent, highly motivated work force is essential to ensure that the interventions reach up to the end beneficiary. Building their capacity is necessary to expand the resource base for public health, especially in a resource strained country like India.

Activity: Panel Discussion

Chairperson: Dr. Susan Rifkin

London School of Economics (LSE)

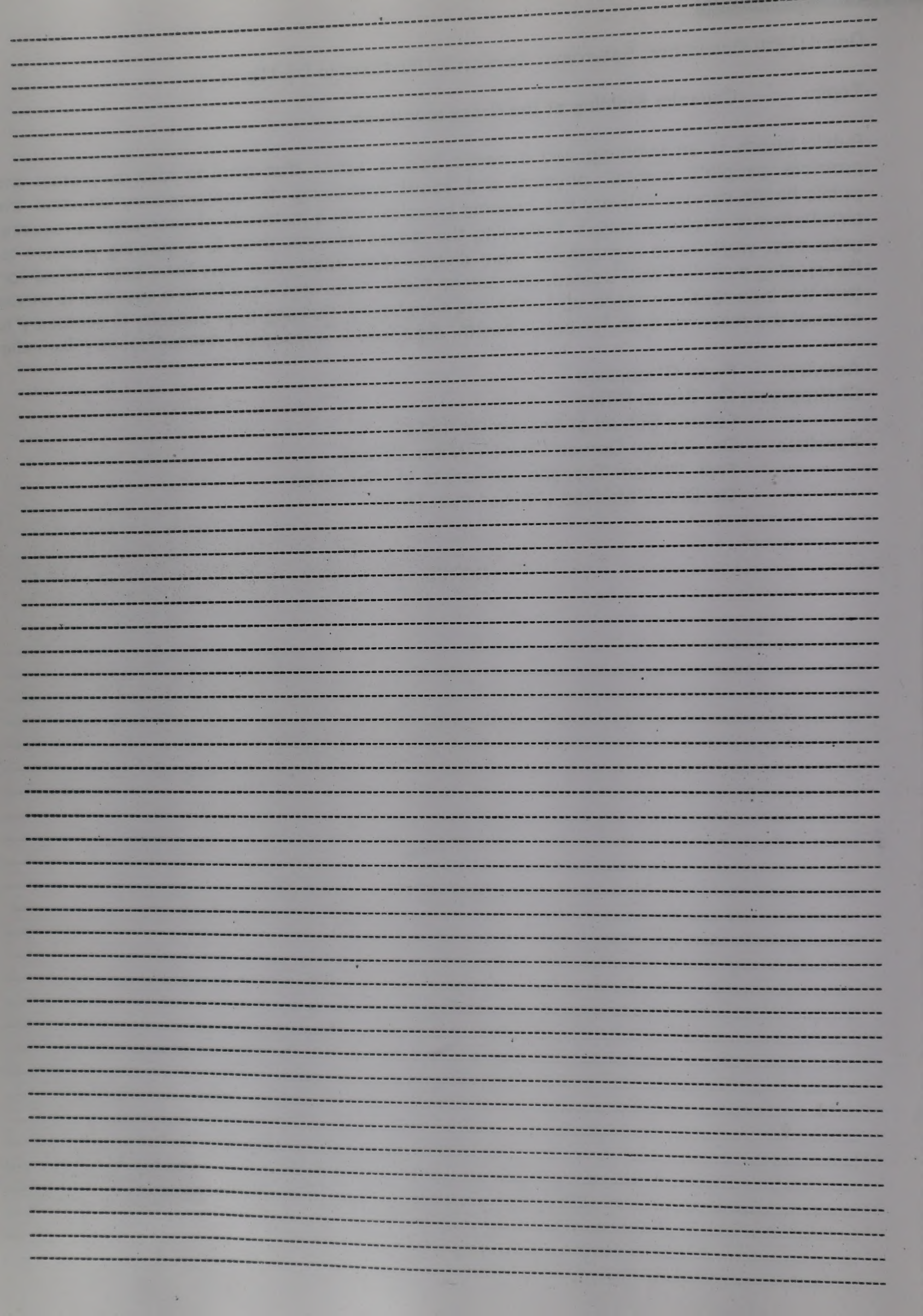
Panelists: Dr. Johny Oomen Cherian (Mitra, Orissa)

Prof. William Toscano (University of Minnesota)

Dr. Dhruv Mankad (Anusandhan Trust)

NOTES

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.



Day 1(19th December, Saturday): Session 3 (00:15pm to 01:00 pm)

Topic: Health Financing in India: Are there enough Capacities?

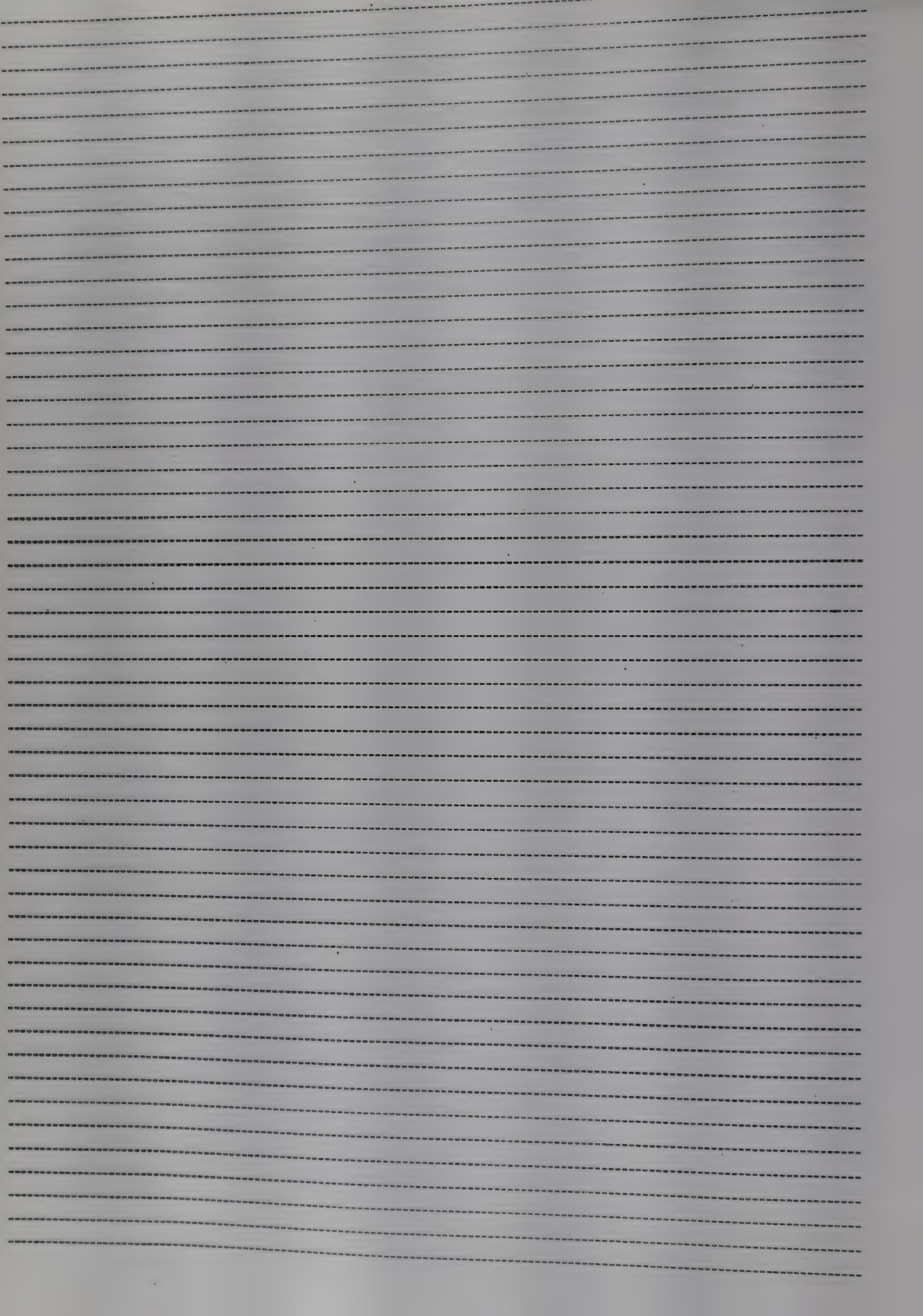
Financing is one of the five control knobs in Health Sector Reforms which determines the Access, Quality and Efficiency of Health Systems and influences the health status, public satisfaction and risk protection. There are a host of options in financing (taxation, insurance, savings account, user fee etc.), all of which have been experimented in different parts of the world. Experiences with each option has been contextual and largely, a mixed one. One common lesson learnt from these successes/failures is the strong need for capacities before instituting any such reform.

Activity: Lecture

Speaker: Mr. Sunil Nandraj (WHO, India)

NOTES

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.



Day 1(19th December, Saturday): Session 4 (02:00pm to 03:30pm)

Topic: Middle level Management Capacity building

Policy planning for Public Health has largely been reasonable in India. But the implementation part has been an issue for debate. Middle level management is the link between the intent of a plan and its outcome. The managers at this level are responsible to transform the essence of ideas into action. With the trend towards decentralization, their role is getting enriched and is becoming more crucial. They are required to be innovative, proactive, flexible, critical and clairvoyant. While the Governments have started realizing the need to strengthen this link and have begun experimenting, the Non-governmental Organizations have rich-experience of building capacities at this level.

Activity: Panel Discussion

Chairperson: Professor C.A.K Yesudian (TISS, Mumbai)

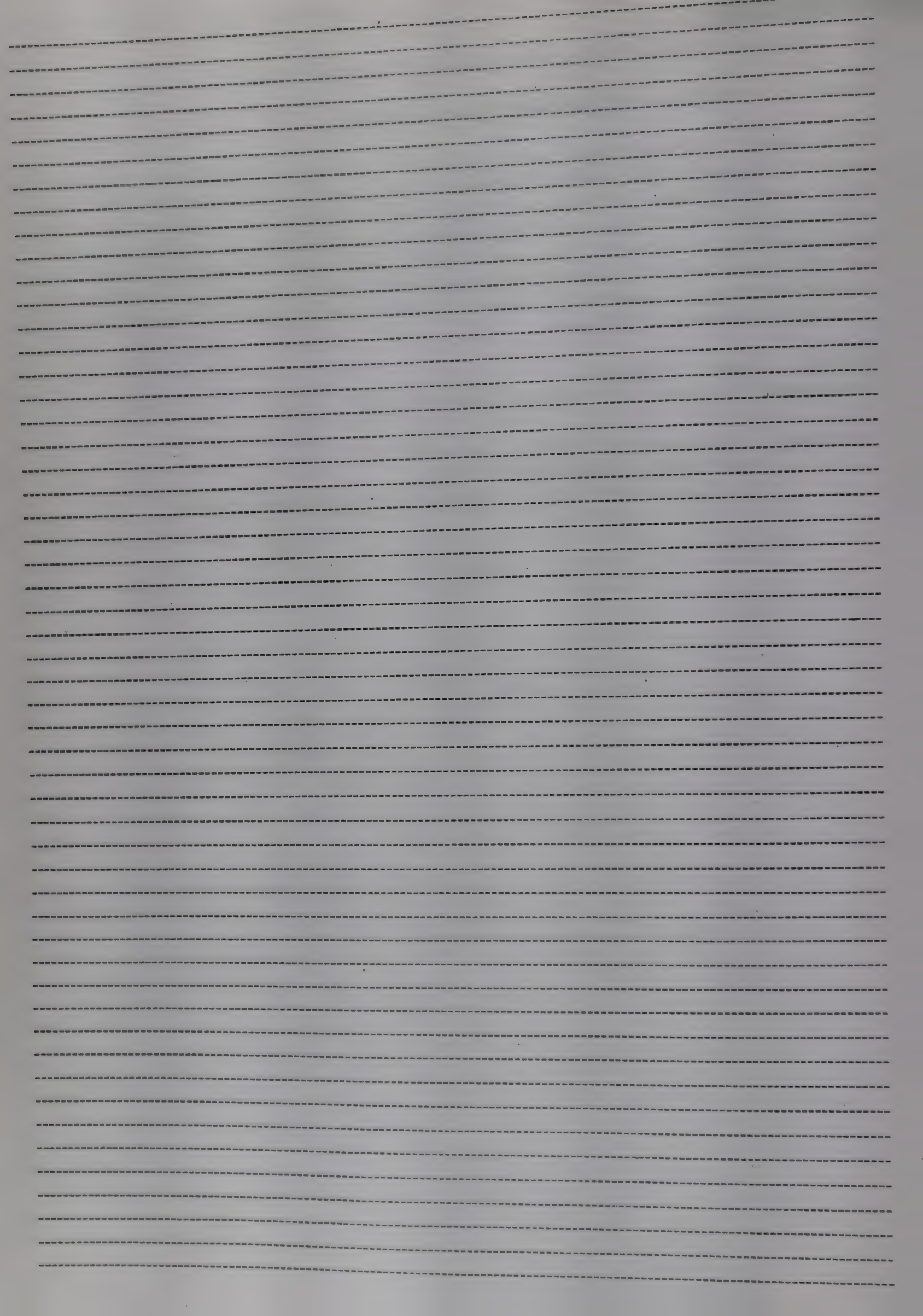
Speakers: Dr. Prakash Doke (SHSRC, Maharashtra)

Ms. Sushma Rath (NHSRC, India)

Dr. Dyalchand (Institute of Health Management Pachod, Pune)

NOTES

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.



Topic: Sensitization of the Health workforce to HIV/AIDS

Activity: Panel Discussion

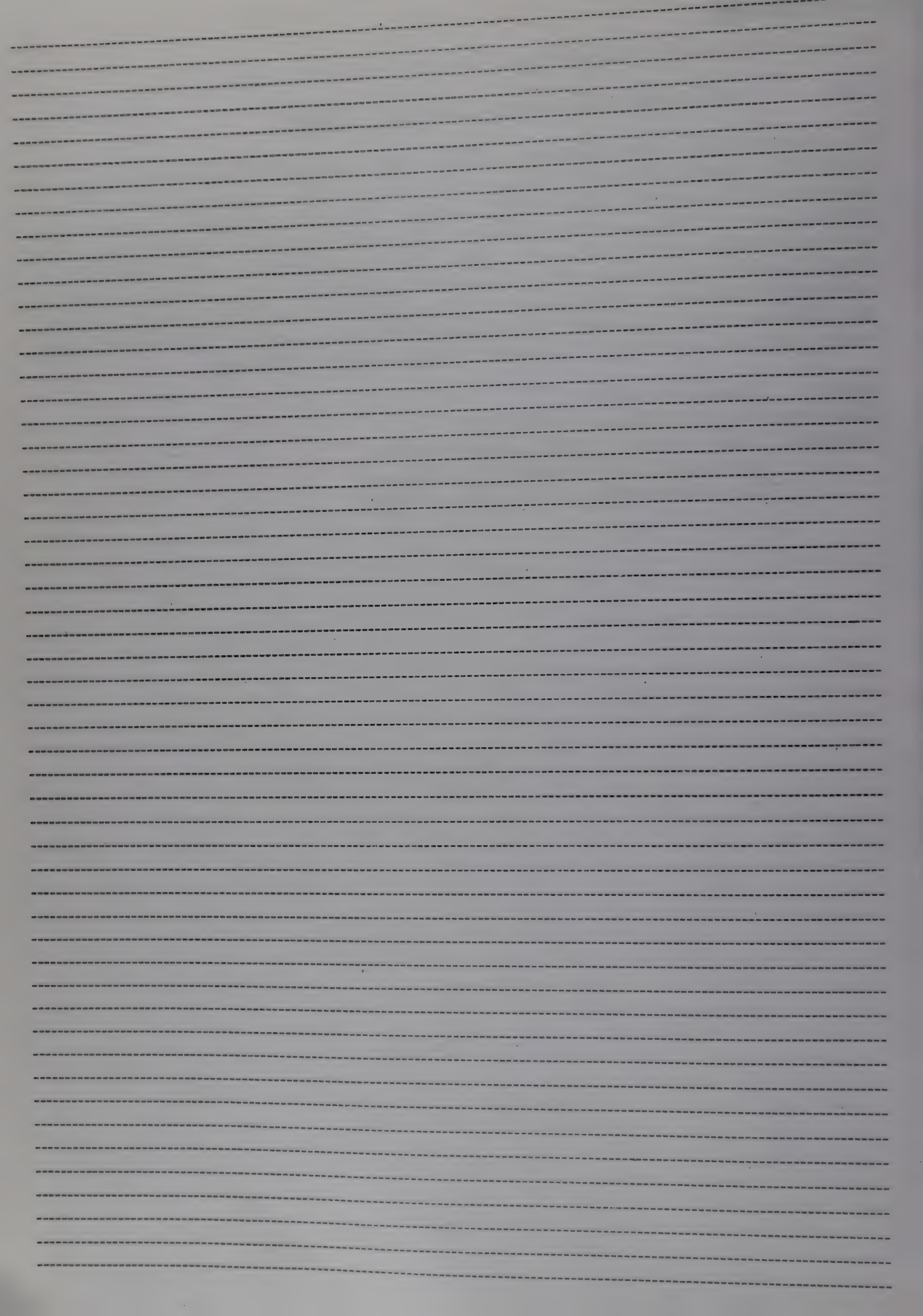
Speakers: Ms. Anna Joy (AVERT Society, Mumbai)

Mr. Eldred Tellis (Sankalp Trust, Mumbai)

Dr. Alka Deshpande (JJ Hospital, Mumbai)

NOTES

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.





02:00:00

04:00:

Every **2** Hours,
somewhere in india, a CUSTOMER
Transasia buys a
product

for the last 30 years, Transasia has towered over its competitors in the field of diagnostic solutions. We are the largest Indian developer, manufacturer and exporter of Diagnostic Instruments and Reagents.

With over 15000 Installations, we are trusted by leading doctors and hospitals across the country. This translates to a Transasia product being used every minute in india.

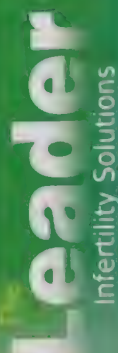
Now imagine, how many customers will have used our product range by the time you finish reading this magazine !



TRANSASIA[®]



Transasia Bio-Medicals Ltd.



YOUR QUEST ENDS HERE!

**Internationally approved
reliable frozen sperm samples
now available in India**



- WE KEEP THE STORK BUSY...!

- High quality donors with extended profile option

- Medical history of 3 generations with background check is done by medical director
 - Psychological screening and counselling done by inhouse counsellor
 - Pre and post freeze analysis is done inhouse as per W.H.O. criteria
- Dr. R. M. ... founder director ... a core member of the committee ... along with ... we claimed ... Androgens ...

An advisory panel of experts which includes Padma Ubshan
Dr. R. M. Bhargava
founder director of CCMH and
a core member of ICMH
committee for ART guide-lines
along with internationally
acclaimed IVF Specialists
Andrologists, Geneticists
Lawyers and Auditors

OUR FIRST
QUARANTINED
BATCH RELEASES
SOON!

Cryos International
Brought to you online by



single
single
single

For further details contact:



India

Cryos International - India Pvt. Ltd.

INDIA'S FIRST INTERNATIONAL SPERM BANK
A new venture of Trivector Scientific International

209, Marathon Max, LBS-Link Road Junction
Mulund (West) Mumbai 400080
Tel +91-9322404849 • +91-22- 25683998
Fax +91-22 25621308
Email: in@cryosinternational.com

Email: in@cryosinternational.com

www.in.cryosinternational.com

Life needs answers



Helping you in Cancer management

Roche Diagnostics 'ECL technology' based tumor marker assays help you in

- Look for cancer – Diagnosis
- Predict how cancer behaves – Prognosis
- Tell if cancer treatment is working – Therapy monitoring
- Look if cancer has returned – Recurrence testing

Electro Chemi-luminescence (ECL)
technology offers:


- High sensitivity to ensure all positive samples are identified
- Short assay time (18 minutes assays) to ensure fast & accurate results
- High specificity, to avoid reporting of false positive results
- Wide assay range to ensure proper detection at very high & low concentrations



Roche cobas e 411

[illegible]

Roche Diagnostics India Pvt. Ltd
Plot No 114, Road No. 15,
MIDC, Andheri (E), Mumbai – 400093
Tel : +91(22) 6697 4900
Fax : +91(22) 6697 4909
Email : india.inquiries@roche.com
www.roche-diagnostics.co.in



Day Two

Day 2 (20th December, Sunday): Session 1 (09:00am to 10:30am)

Topic: Community Based Health Insurance: A means of Community Capacity Building

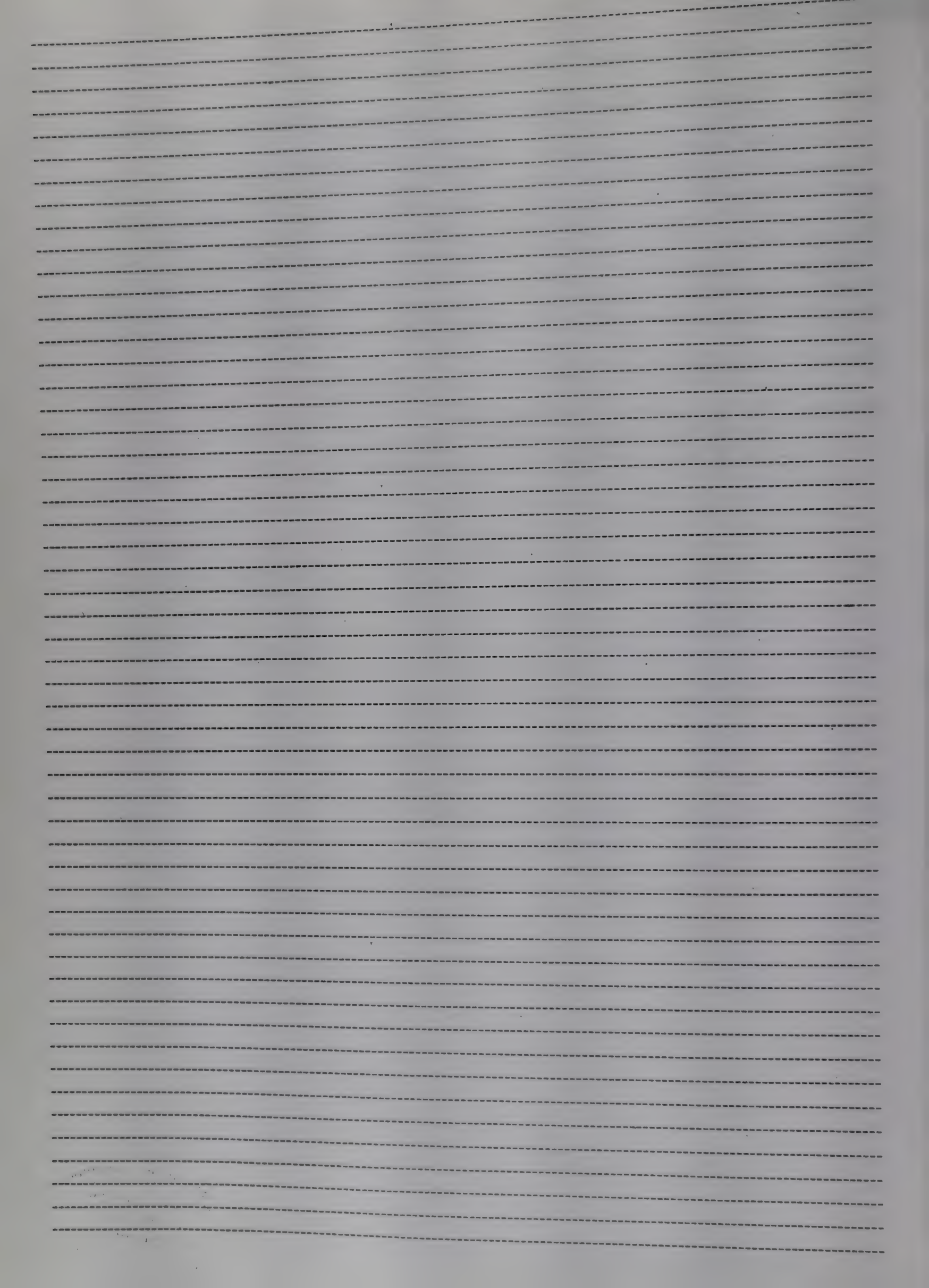
As per World Health Organization, financing of the Health System is an important determinant of its performance. In a country like India, where more than two-third of health expenditure is out of pocket and when NRHM mission document reinstates that financial burden is pushing people below poverty line (or making them borrow heavily), the issue becomes far more important. Community Based Health Insurance (CBHI) tries to mitigate this problem. And that, in itself is building capacity – at system's level by strengthening financial resources. It also has the possibility of addressing catastrophic health expenditure, at a more personal level, empowering community to achieve their right to health.

Activity: Speaker's Presentation

Speakers: Dr. N. Devadasan (IPH, Bangalore)
Dr. M. Bhatia (London School of Economics)
Dr. E. Pitchforth (London School of Economics)

NOTES

[illegible]



Day 2 (20th December, Sunday): Session 2 (10:45am to 01:00pm)

Topic: Sustainable Technologies in Healthcare

Quality and cost are the two main drivers in Healthcare. But quality comes at a cost. With technologies changing like fashion, it is becoming difficult, both from financial and administrative angle, to keep up with market trends. Cost becomes more of an issue in India where the penetration of insurance is still meager. In these times, we require low cost technologies which can be sustained over a longer period. This will make life easier for both, the providers and the patients.

Activity: Speaker's Presentation

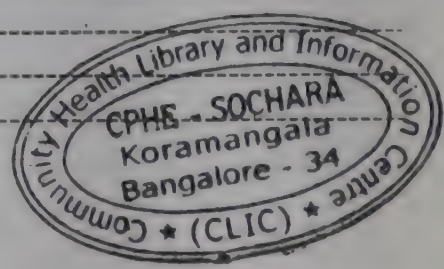
Speakers: Mr. Sameer Mehta (HOSMAC)
Dr. Joy Chakravarty (Hinduja Group of Hospitals, Mumbai)

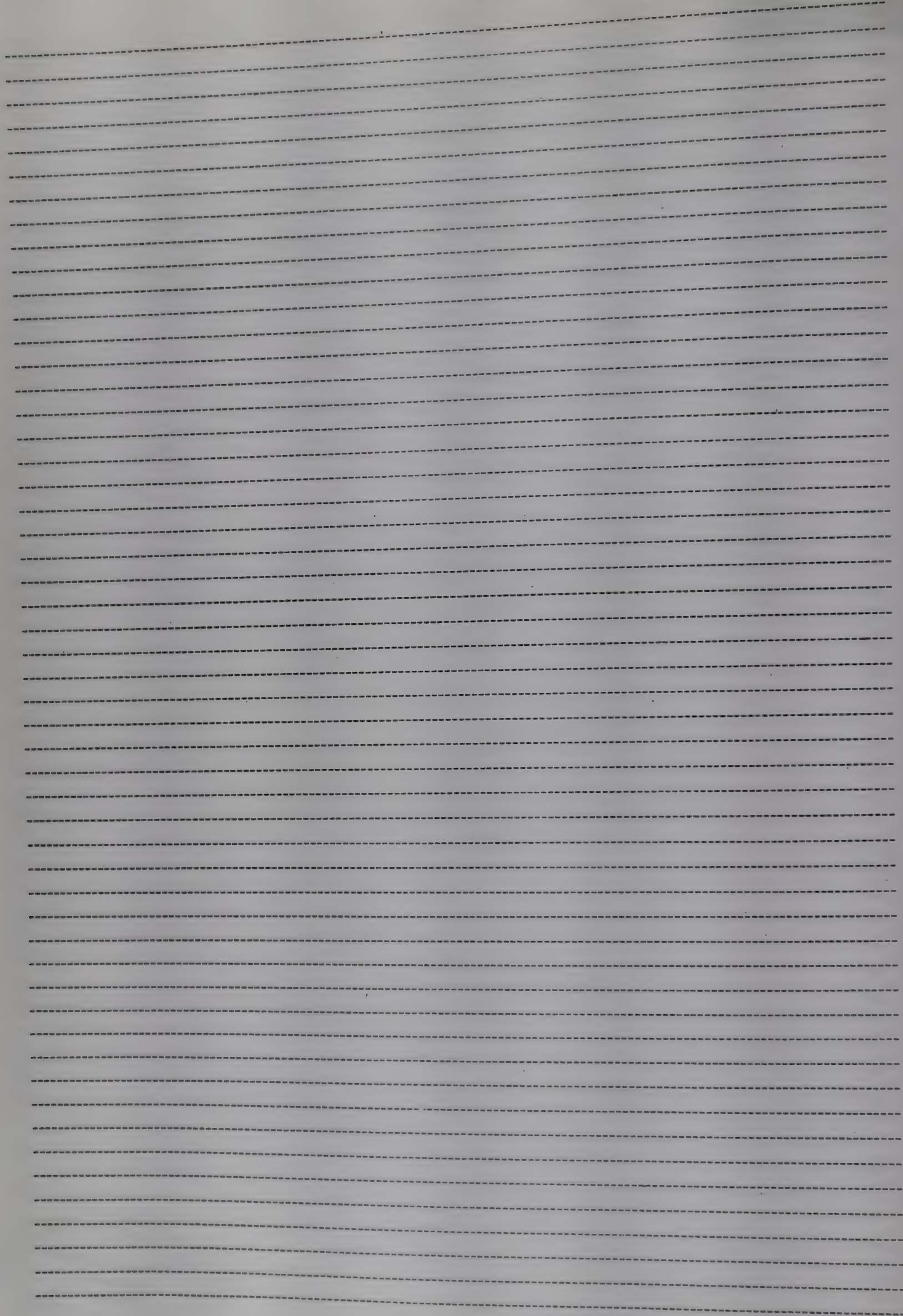
NOTES

A large sheet of white paper with horizontal ruling lines, resembling notebook paper. In the bottom right corner, there is a circular library stamp.

Health Library and Information
CPHS - SOCHARA
Mangala

PH-100
14022 P01





Day 2 (20th December, Sunday): Session 3 (02:00pm to 03:30pm)

Topic: Breaking new grounds in Hospital Financing

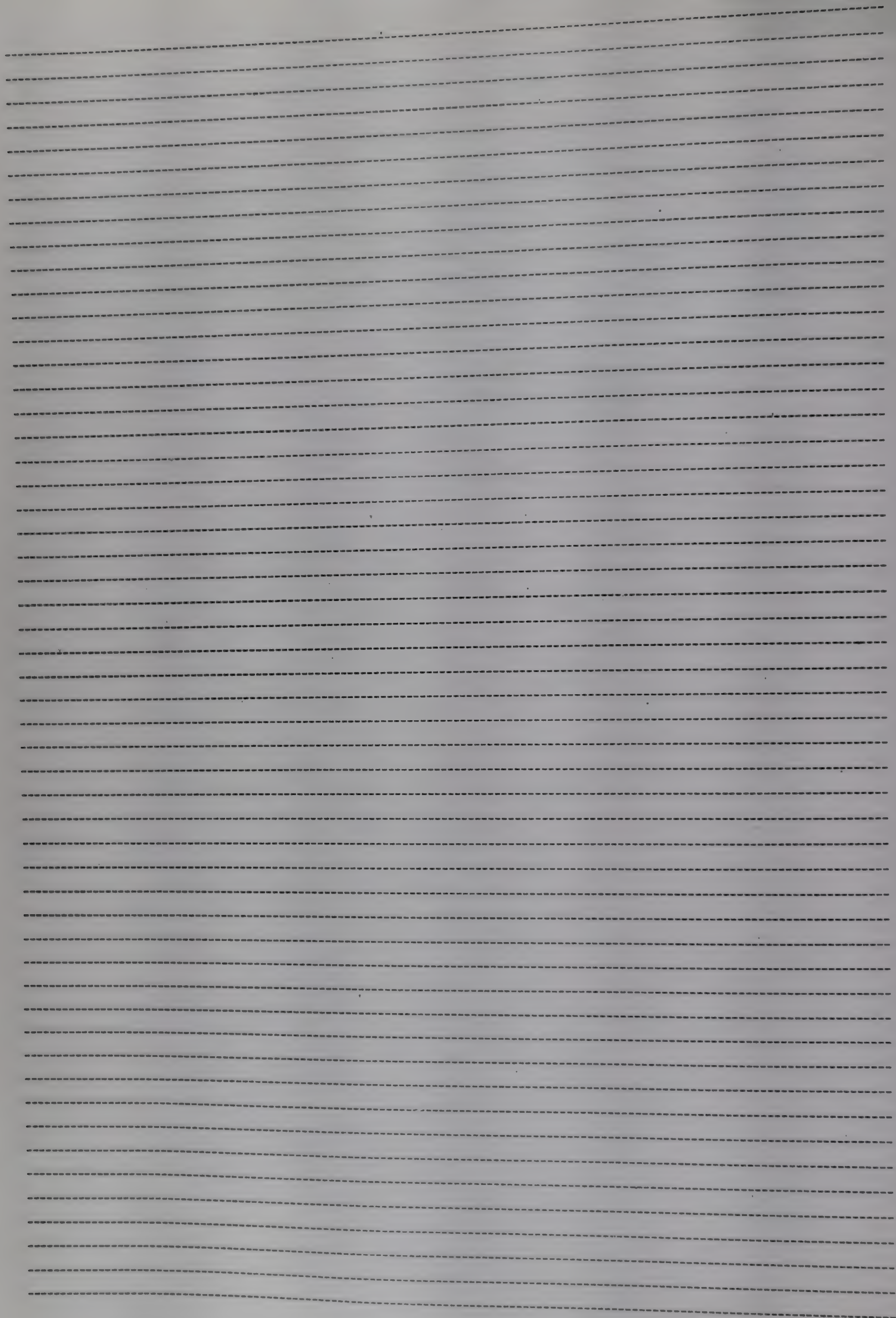
Healthcare has transformed from a sector to an industry. It caters to customers which is a mix of those who can pay and those who can't. With entry of health insurance (private and community based), the traditional notions about hospital financing are changing. But this is not the only option available to turn the knob. At the same time, new ways are being developed to increase the allocative and technical efficiencies in hospitals. These changes are occurring in real time and are set to redefine the future of hospitals.

Activity: Lecture

Speakers: Mr. Abishek Bhagat (YES Bank)
Mr. Prashant Naidu (Apollo BSR)

NOTES

[illegible]



Day 2 (20th December, Sunday): Session 4 (03:45pm to 05:15pm)

Topic: Strategic Business Models for Hospitals

The competition in healthcare market has become borderless. It is no longer local, regional or national. Hospitals, being open systems, have to adapt with the white water changes in technologies across the world. To survive in these times of hyper competition, the top level managers have to go beyond forecasting and exercise what is known as 'backcasting'. They are required to formulate strategies which are not only futuristic, but which will define the times to come.

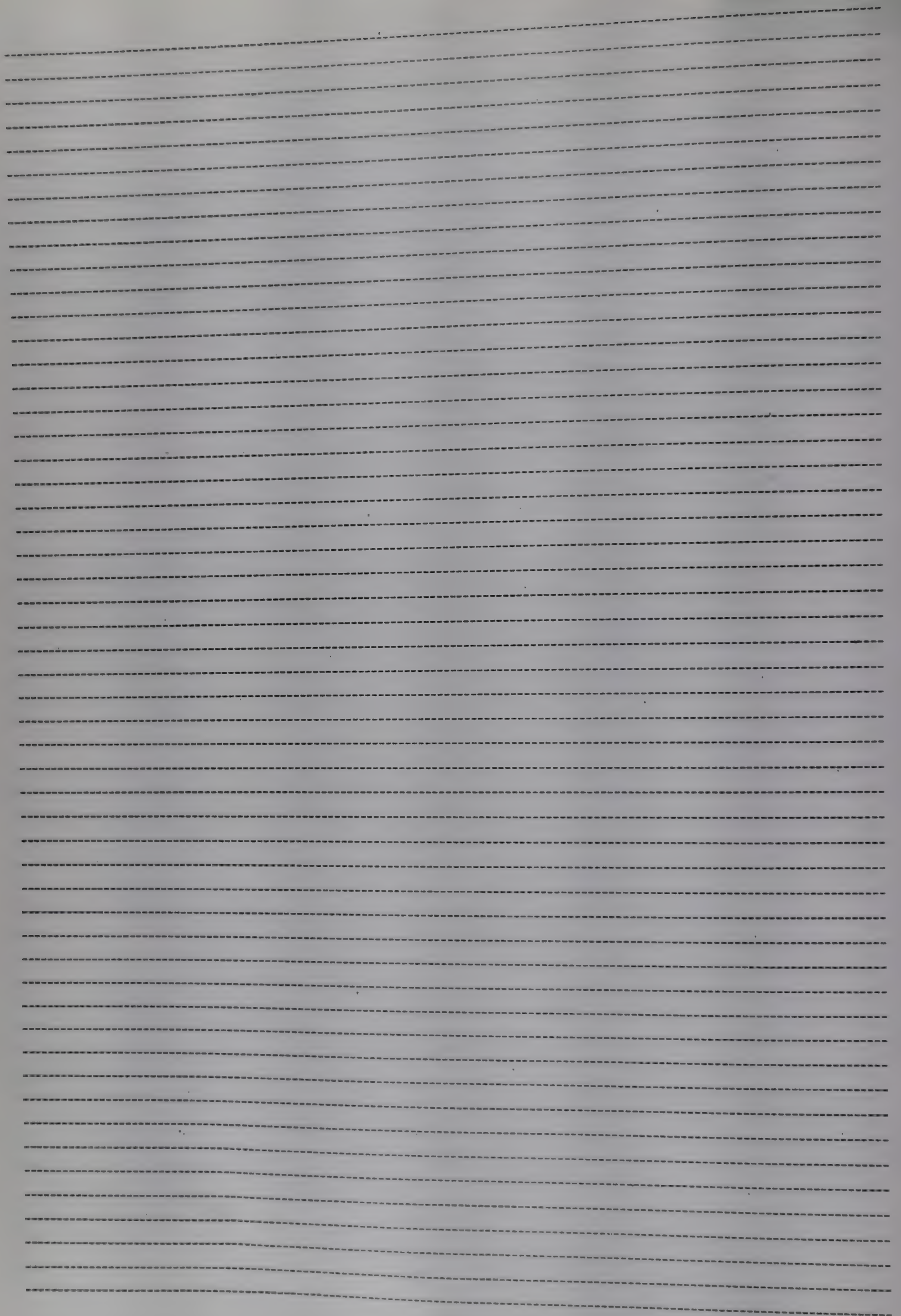
Activity: Panel Discussion

Chairperson: Dr. Vikram JS Chaatwal (Reliance Health)

Speakers: Mr. Sanjeev Vashisth (Fortis Hospital)
Dr. Ashwin Naik (Vaatsaiya Hospital)
Dr. Keerti Pradhan (Right To Sight)

NOTES

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.



Day 2 (20th December, Sunday): Session 5 (05:15pm to 06:00pm)

ANTERPRERNA (Business Plan Competition)

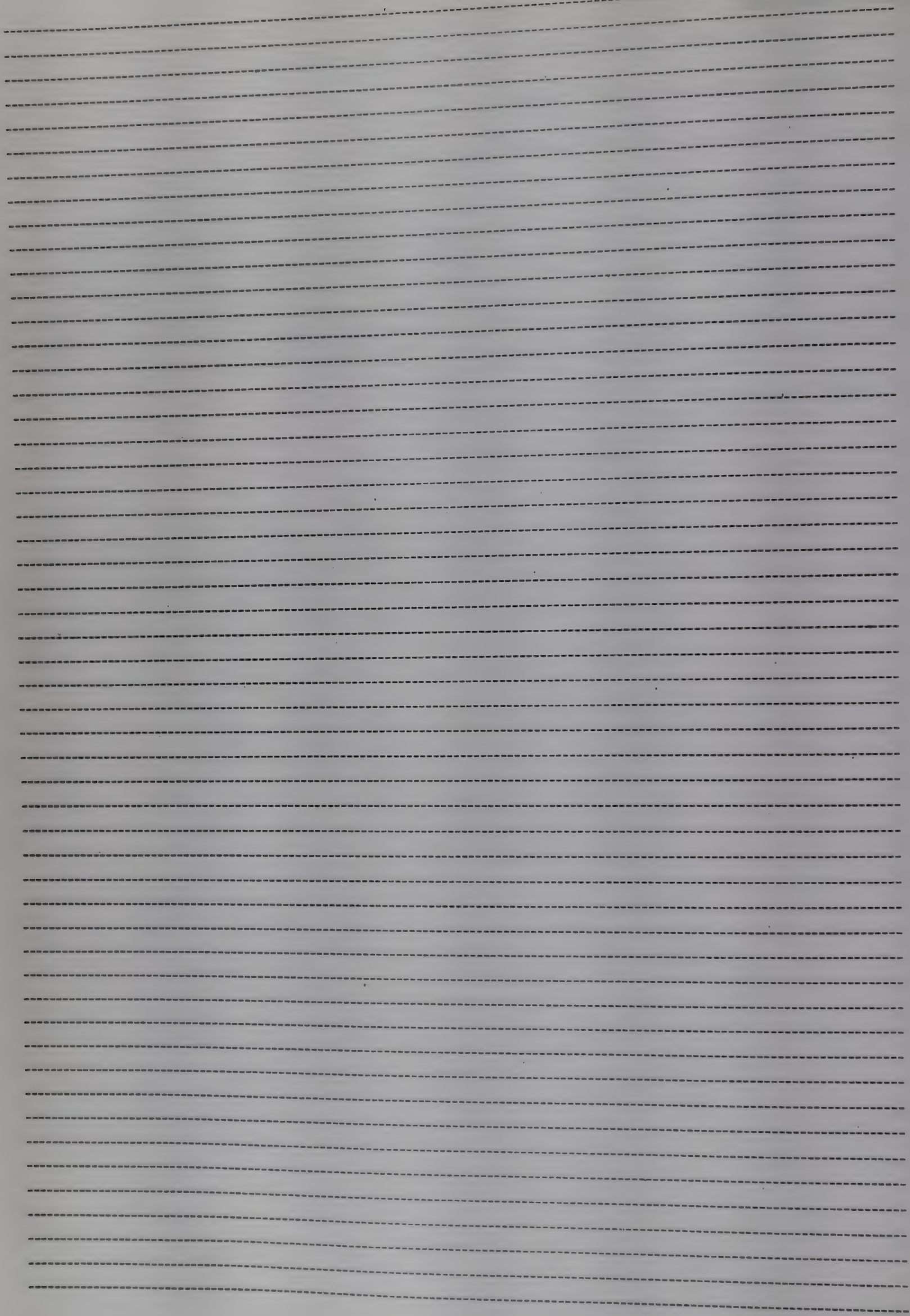
Topic: Innovative Health Care Delivery Models

To cater effectively to the billion-plus population is a real tough task. We need to innovate to reach out effectively to those still unreached. With rapid advancements in knowledge and technology, we have to look out for newer models to keep ourselves abreast and come out with actions that are not only technically effective but also efficient. Keeping in view the importance of effective health models and the urgency to do so, we need young entrepreneurs to come up with practical, feasible and sustainable plans/models that would integrate with the present system without a hitch and yet provide the necessary impetus for the achievement of equitable and egalitarian healthcare system.

Activity: Presentation

NOTES

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.



Quality In Hospitals

'QUALITY' IS A WORD THAT WE USE EVERY DAY; what exactly does it mean in a Hospital? All of us want goods and services to be of a 'good quality' or 'high quality' if possible. All of us know that to get anything of a 'high' quality, more effort needs to be put in and the cost may be a little higher, yet we justify the higher efforts and cost with phrases like 'No Compromise' etc. In hospitals 'Quality' is a separate department.

WHAT IS QUALITY?

There are numerous ways of looking at Quality. Apart from being 'Best', Quality may also be thought of as 'Value for Money'. This means that we get goods or services of a fairly good quality yet the cost is not very high. Naturally this idea of quality is popular with the consumer, but the supplier will have to bear higher costs to maintain quality and yet offer Quality Services at a lower cost to be considered 'Value for Money'. The supplier will benefit by creating value for his business and getting the loyalty of customers. At the basic level, getting 'Quality' means getting exactly what is promised or offered or named.

CULTURAL BACKGROUND

The concept of Quality may differ from person to person and culture to culture. The need for Quality will also differ for different goods and services. People may accept poor quality in disposable items because ultimately they are to be thrown off. Yet the same people might insist on eating the most expensive type of wheat or rice because they are concerned about their food.

Some people will accept a cheaper television with fewer features because they cannot afford a costlier piece with the latest hi-fi features. This is not a compromise on quality but a compromise due to necessity. But the same people may spend more when it is a question of medical treatment for a member of the family.

QUALITY IN HEALTHCARE

What about Quality when it is a question of healthcare? Can we honestly say that a little compromise here and there will not affect the outcome of medical treatment given to a patient?

The answer is a big NO. Any compromise in the healthcare service industry may lead to nasty outcomes.

A very unfortunate and sad example is the recent outbreak of hepatitis in Gujarat due to reuse of syringes. It is a standard protocol to discard and destroy disposable needles and syringes. It was not done, the syringes were reused. Syringes used on infected patients were also used on other patients without sterilization. The result was that the other patients,

innocent people, were infected with hepatitis and died. They should never have been infected with hepatitis except for the fatal reuse of syringes which should have been destroyed and burnt after first use.

In healthcare, Quality has to be taken care of in infrastructure, equipment and services. The actual quality in healthcare no longer depends on how well qualified a doctor is but how adequate his team is and how well equipped his hospital is.

Can the doctors and the paramedical staff work as a team to face emergency situations? Does the hospital have life saving equipment in working condition? An answer of YES to all these questions enables 'QUALITY' in a hospital.

EQUIPMENT

The better the quality of equipment, the better would be the outcome. This is so obvious, but here there is a clash between profit and commitment. The philosophy of the top management of a hospital will decide what equipment the hospital will buy. There are business pressures like competition, business cycles, newer technologies which dictate what equipment is taken. If a hospital's equipment is the best in the world it is of course ideal. But if cost constraints do not allow the best, the equipment should at the least be functional. It must satisfy the needs of the patients.

INFRASTRUCTURE

Then comes the infrastructure. Is it ideally designed? Do the patients have the least difficulty in reaching the hospital? Once inside the hospital is the structure safe and solid to hold the number of people that may be expected to come? Are the electrical systems safe? Are there adequate lifts and are they reliable? Has the relevant inspector checked the lifts for safety? Are the lifts certified? How is the building protected against fire? Are there enough fire extinguishers? Is the fire fighting system checked and certified by the relevant departments? Is a mock fire drill done from time to time to train the staff about how to react in case of a fire? Is the building dust free and air conditioned? A centrally air conditioned building becomes important in infection control. Pathogenic bacteria cannot flourish in cooler temperatures and hence severely burnt patients who are prone to infections are kept in chilled rooms. Also, a centrally air conditioned building will be relatively dust free and hence infection free because the minute dust particles may harbor disease producing (pathogenic) bacteria.

There are hundreds of such questions which need to be addressed correctly before the adjective 'Quality' can be applied to a hospital. All the above do not constitute luxury. Most of the above items are necessary basics in a multi specialty hospital.

SERVICE

Perhaps the quality of service is the most crucial component of Quality in a hospital. Service includes not only the medical and surgical services, but also each and every service that a patient or his/her relative might need during hospital stay.

In the times of nursing pioneers like Florence Nightingale, the concept of quality did not exist because equipments were rudimentary, infrastructure was never custom made for a hospital, any building was converted into a hospital as and when the need arose. But what made Florence Nightingale a saint amongst nurses was that she dedicated herself to serve patients. Today she is a cult figure for nurses. Nurses dedicated to nursing think of her as a Godlike figure and follow her precepts.

What is 'Quality' in nursing care? A smile as soon as he or she enters a patient's room (it must be remembered that a nurse means both a male or a lady nurse), talking to patients, encouraging them to face their troubles bravely, using light humor to make patients smile, touching them gently, washing and cleaning them with empathy and most important of all,

enjoying the work and thinking about nursing as service to society and God. There are other routine procedural things like being available 24x7, informing patients before any procedure, explaining patients about a procedure if it involves pain or discomfort for the patient and so on.

TRAINING

Better Quality in nursing care is achieved through both motivation and training. Training has to be continuous. As new staff is appointed, they need to be trained to maintain the hospital standards. Older staff needs to be updated about newer medical methods and techniques. All staff needs to be reminded about smiling at patients again and again as nursing is a tough profession.

What is true for nursing is also true for all other ancillary services in a hospital. Apart from nursing, a hospital has attendants who help patients in personal matters, catering staff who serve food, Patient Relationship Officers who are an interface between the patient and his/her needs, Medical Officers who monitor the patients and so on. If a hospital gives the best service to a patient, and during the discharge process if a billing person behaves rudely, the whole treatment experience may be marred. If the ambulance driver who drops the patient home or at the airport demands a tip, again that will reflect very badly on the hospital.

ACCREDITATION

Ultimately what are the rewards of Quality? Does investing more money in building an ideal hospital and buying state of the art equipment and gathering the best of staff to run the hospital ensure that patients will come to that hospital?

Answer may be yes, provided patients come to know about the hospital. How will people know how good a hospital is? Is there any benchmark which shows how good the hospital is? Of course there is. Just as good quality food items have the 'AGMARK', well maintained hospitals who follow all the good practice procedures and protocols can also apply for and get accreditation from the Quality Council of India through National Accreditation Board for Hospitals and Healthcare Providers (NABH). International bodies like Joint Committee International (JCI) also give accreditation and certification.

Such certification makes the hospital known as a good institution. This makes it easier for corporate decision makers whether to sign a contract with a hospital for the treatment of their employees. Thus an accredited hospital has a much higher chance of being empanelled by companies which offer free or subsidized medical treatment to their employees. There are a few more areas and departments which must be mentioned while discussing Quality in the Healthcare Service Industry.

MEDICAL WASTE MANAGEMENT

Hospital waste is special because it is a potential source of spreading infection. Hence first and foremost all hospital waste must be separated in four types of containers which are color coded - blue, yellow, black and red. Sharp objects like needles go in one container, soiled cotton wool and gauze in another, food waste has a separate container and so has paper waste. The approximate amount of waste that may be generated by each hospital is estimated by standard of reckoning. If a hospital generates less waste, the authorities of that hospital may be questioned as to whether they are throwing waste into garbage dumps.

OPERATION THEATRES

OTs are the most critical rooms in any hospital. After every surgery of a wounded patient the OT will be cleaned and fumigated to prevent transmission of infection from one patient to the other. All OTs will undergo deep cleaning and fumigation once a week. All the instruments used in each and every operation must be first washed and then sterilized as per predefined protocols before the next operation. All the clothes that the surgeons and anesthetists wear during operations must be similarly washed and then sterilized.

INFECTION CONTROL

This is perhaps the most important section of any hospital. The aim is to prevent transmission of infection from one patient to the other. It is best done by preventing any accumulation of dirt anywhere. The toilets, the floors, each room and each bed for that matter are kept hyper clean.

MEDICAL INSURANCE

Now-a-days, most of the times the payments for medical treatment is done through Medical Insurance. If a patient has a Medical Insurance he/she needs to claim the cost of the treatment from the insurance company. A good hospital will have a separate cell that helps patients get approval and payment for treatment from their insurance companies. This eases the burden on the patient.

The quality of food served to patients in a hospital needs to be constantly monitored. For environmental conservation, non renewable natural resources like water need to be harvested from rain. All possible measures must be taken to avoid the waste of both electricity and water. Thus Quality in the Healthcare Service Industry is not a onetime investment. It is a person independent continuous ongoing process.

Capacity Building For Mental Healthcare In India

ABOUT 2-5% OF INDIA'S POPULATION SUFFERS from some form of mental or behavioral disorder. Around 1% has a serious form of mental disorder requiring urgent care at any one point of time. No less than 10-15% of those attending general health facilities have a common mental disorder. There are around 4,00,000 wandering mentally ill persons in India. They are often seen, in various states of mental distress and physical abuse, around railway stations, bus stands, and pilgrim centers and on street corners. They are the 'invisible people', separated from and/or neglected by their families.

The wandering mentally ill belong mainly to economically backward and socially marginalized families. Nine out of 10 have diagnosable and treatable mental disorders; four out of five have significant co-morbid physical health problems. The stigma and economic burden of mental illness are the main reasons why it is so poorly treated. It is social ostracism and sheer indifference in one sense and also widely held beliefs of being possessed by spirits or character defects etc when it comes to mental disorders.

There have been many models in mental healthcare where a sincere attempt has been made to tackle it from its roots in terms of detection, diagnosis, treatment and rehabilitation. One of the models which are coming to the fore is the community based model for mental healthcare where people who are mentally suffering are able to stay in the community and achieve medical, social and economic rehabilitation. There is a huge transformation from the hospital approach where mentally ill were usually confined, sometimes bound in chains and were considered as violent. (Erawadi incident in Tamil Nadu). The challenge though remains in detecting and diagnosing mental disorders. With exceptions, not only in community but the medical fraternity and doctors neglect their training in internships and subject knowledge for the science of psychiatry. It is considered as an optional subject for marks so is usually left out during the examinations.

CAPACITY BUILDING

1. There is a dire need to engage in capacity building to create awareness and treatment for mental disorders in the country and engage in meaningful treatment and rehabilitation for mental disorders. The focus should be on creating trained manpower at all levels that can help in detecting and diagnosing mental disorders and looking at efficient mechanisms in delivering quality mental health care.
2. Psychiatrists, psychologists, social workers, psychiatric nurses, occupational therapists, families, self help and advocacy groups are required to act in concert, as a community mental health service care team.
3. The government, public sector, private sector, voluntary sector, families, committed individuals and affected persons need to come together as a broad federation on a common platform, subscribing to agreed principles and objectives.
4. There is a need to build capacities for continuous psychological support and counseling to patients and their family members and break down various myths and misconceptions associated with mental health problems. This will break the stigma surrounding mental health disorders. There is a need to encourage the formation of self help groups of people with mental illness and their families

5. There is a need to build linkages and networking for referral services and set up a legal aid program and advocacy where any kind of information related to human rights, legal and ethical issues can be provided telephonically or face to face (e.g. myths about use of electroconvulsive therapy).

6. The capacity building needs to create gender and consumer centered data on the quality of service delivery, which can provide the basis for a recommendatory document on best practices as well as the basis for education and training in mental health, gender and ethics.

7. The focus should be on developing capacities of selected NGOs/organizations in specific project management skills, especially documentation, project preparation, accounting, monitoring and reporting for mental health disorders.

8. Apart from conventional treatment regimes, India has a rich tradition of local health practitioners (vaids/dargah fakirs) who have helped mentally ill people staying in rural areas and at grass root level where healthcare delivery mechanisms are nonexistent. Their capacities can be utilized by training them in general mental disorders detection and amalgamate traditional and modern techniques to create a holistic mental healthcare model.

9. Capacity building should also centre on building alternatives for the western psychiatric models for treating mental disorders and evidence based documentation for the same. These are few steps which could bring a sea change in the mental healthcare scenario in our country. Overall, our objective for capacity building should be a strong health care system which itself will provide an impetus to all the health programs in general and mental healthcare in particular.

REFERENCES

- http://www.gujhealth.gov.in/Medi_servi/pdf/Key%20Statistics%20of%2014%20Pilot.pdf
- <http://infochangeindia.org/2003100392/Health/Features/NIMHANS-recommends-the-Banyan-model-for-mental-healthcare.html>
- <http://www.google.co.in/search?hl=en&q=ERAWADI&meta=&aq=f&oq=>
- The Mental Health Act 1987, the People with Disability Act 1995 and the Rehabilitation Council of India Act 1992
- Mental health in development and CBR – Basic needs India

IT and Health:

Some observations on IDSP

There IS A NEED TO INTEGRATE HEALTH CARE information and surveillance mechanisms with information technology to enable real time decision making for healthcare delivery and evidence based response. Information-technology is still but a tool and it is important to have a robust and efficient health care system with trained manpower in place. I would like to share my observations during the course my internship in the context of the Integrated Disease Surveillance Project. This was a study assigned by the Directorate of Health, Government of Maharashtra, in Nagpur district, India in March 2008.

The Integrated Disease Surveillance Project (IDSP) would enable India to detect early warning signals of impending outbreaks and help initiate an effective and evidence based rational decision response in a timely manner. It focuses on the feasibility of indicators used and quality of data collection and reporting while using information technology as a tool to generate evidence based information. It is an effort to use e-health to generate precise real time evidence for decision making.

The objective of the study were as follows:

1. To evaluate the quality of data collection and reporting during data travel from the grass root level at the primary health centre to the headquarters in Nagpur district, India.
2. To provide recommendations for capacity building and training to enhance the quality of IDSP.

The problem statement was to evaluate the quality of data collected and data travel to the higher level in IDSP in Nagpur district of India. The data was collected with the help of open ended interviews of various key health personnel, right from the grass root level to the district headquarters. The data was analyzed manually using qualitative analysis techniques. The quotes from the respondents were grouped together to condense the findings.

CONCLUSIONS

1. There is a need to focus on the quality of data collection and reporting at the grass root level as the data travels upward without any change after it leaves the primary health centre and is used for analysis to initiate an evidence based response.
2. Information technology is a tool to achieve best practices by improving the entire process and not a panacea for poor quality data collection and reporting.

RECOMMENDATIONS

1. There is a need to train the grass root health workers about the importance of the IDSP and create awareness about its ability to generate an early response in case of an outbreak.
2. There is a need to train the local private practitioners to make the process sustainable and gain wide acceptance. It is important not to keep IDSP as a standalone exercise and integrate it with the existing Health Management Information Systems (HMIS).

3. There is a need to build capacities of health care personnel especially at the sub-centre and primary health care centre level to collect quality data. The burden of multiple forms and multiple reporting hierarchies leads to poor data collection and reporting and neglect of health care work. A lucid reporting format and an accountable, simple hierarchy which can help health care workers balance work with objective reports is the need of the hour.
4. There is a need to encourage unbiased reporting by building community capacities and creating awareness about health care issues.

Dr. Sujay Joshi (drsujayjoshi@gmail.com)
Student [MHA-Health (2008-10)]

ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA) SCHEME - An Insight of The Existing Scenario

INTRODUCTION

The ADVENT OF THE NRHM IN 2005, brought with it a key component called ASHA (Accredited Social Health Activist), as a means to effectively utilise manpower to address the health care needs of rural India, by acting as an interface between the public health system and the community. The largest CHW (community health worker) scheme in India, ASHA involves selecting a female from the community she belongs, as a means to, create awareness of health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the health services. Empowered with knowledge and a health care kit, she is meant to be the first port of call for any health demands of the community.

An ASHA is a woman resident of the village in the age group 25-45 years who has been shouldered the responsibilities of promoting universal immunization, referral and escort services for reproductive and child services (RCH services) and other health programmes. The figures states, from the year 2005 till 2009, about 7,30,909 ASHAs have been selected for this purpose.

This research study aims to provide an insight of the existing scenario of the selection, training, work responsibilities, support system, incentives provided to the ASHAs in a remote hilly block, Jawhar, situated in the district of Thane in Maharashtra state and tries to provide a base and arouse the need for more studies to be conducted on the same.

BACKGROUND

In the Jawhar block 219 ASHA workers are working under the scheme. There is one CHC and four PHCs in the block. Following table I is showing the name of PHC and the numbers of ASHAs which are working under the every PHC. The numbers of ASHAs are based on the population.

Name of PHC	No. Of ASHA's working
JAMSAR	60
NANDGAON	32
SAKHARSHET	70
SAKUR	57
TOTAL	219

All the ASHAs had finished their 3rd Training Module till date. Almost all ASHAs had finished a year of work in Community. ASHAs are being provided with ASHA kit. ASHAs working in JAWHAR Block don't have any fixed salary, instead they are provided with Incentives.

All the ASHAs had finished their 3rd Training Module till date. Almost all ASHAs had finished a year of work in Community. ASHAs are being provided with ASHA kit. ASHAs working in JAWHAR Block don't have any fixed salary, instead they are provided with Incentives. Details of Incentives provided to ASHAs are shown in Table II:

REFERED PATIENT INCENTIVES

REFERED PATIENT	INCENTIVES
Pregnant Woman(only 1 st & 2 nd Gravida) under JSY	600/-
Tubectomy (BPL Patient)	150/-
N.S.V. Patient	200/-
DOT's Provider(completion of treatment)	250/-
T.B. Patient	50/-
Leprosy	50/-
Malaria	60/-
P. Vivax	25/-
Malaria I.P. Patient	25/-
Epidemic in Community	25/-
>5 yr Dehydration I.P. Patient	25/-
Vaccination in Community (100%)	750/-
Vaccination in Community (90%)	500/-
Catract	175 -
Attending Meeting(including food)	150/-

Table II

ASHAs from Sakur PHC & 13ASHAs from Nandgaon PHC are being trained by BAIF NGO. Rest all ASHAs are being trained by the Government of Maharashtra. Trainers include M.O.s, L.H.V.s (Lady Health Visitor), H.A.s (Health Assistant). Trainers are receiving training from Thane office. For Monitoring over ASHAs a new post has been created called "BLOCK FACILITATOR". BLOCK FACILITATOR is generally a woman, has education slightly higher than ASHA (10th onwards). She visits twice in a month to ASHAs place and collect the record of referral cases by ASHA. Also she visits patients with ASHA in the community and counsel them. The Block Facilitator submits the report of records to PHCs. She has a fixed salary of Rs. 3000/month.

METHODS AND SUBJECTS

Out of the total 219 ASHAs 40 ASHAs were selected by simple random sampling from all the four PHCs. A questionnaire was prepared which had questions pertaining to selection, training, functioning, support system, incentives and job satisfaction. An interview schedule was used as a method to ask the questions to all 40 ASHAs. In-depth informal interviews were conducted with all four Medical Officers of PHCs, 2 LHVs, 1 HA, 2 Gov. ASHA trainers and 1 NGO ASHA trainer. Responses of the in-depth interview, quotes and observation of researcher were documented. SPSS software was used to analyze the data.

RESULTS

Average years of schooling of the ASHAs was found to be 8.65 yrs. Average duration of working as an ASHA was 11.65 months. **SELECTION:** only 30 ASHAs (75%) were found to be selected in the gramsabha. 6 ASHAs (15%) didn't have any sort of appointment letter from the Government of Maharashtra stating that they were working under the ASHA scheme. Only 1 ASHA (2.5%) possess an ID card as an ASHA worker. All the 40 ASHAs (100%) were found to be married as per the rule. **TRAINING:** 12 ASHAs (30%) were found to be trained by the Government of

Maharashtra and NGO BAIF-MITTRA. Out of the 40ASHAs, 13ASHAs (32.5%) recollected incidences of absenteeism amongst other ASHAs during the training process. **WORK RESPONSIBILITIES:** An average day of working of ASHAs was found to be 4.9 days in a week. Average hours of working of an ASHAs was found to be 1.6 hrs. 6 ASHAs (15%) didn't possess any ASHA kit provided by the authorities. 30 ASHAs (75%) claimed an irregular supply of the drugs from the PHC. Only 8 ASHAs (20%) were found to be conducting community meetings. 12ASHAs (30%) were found to be working as a DOT's provider successfully. Only 3 ASHAs (7.5%) said that they had received some sort of on-the-job training from ANM or MPW. 30ASHAs (75%) responded that they had faced problems while working in the community. **SUPPORT SYSTEM:** All the 40ASHAs (100%) responded that they had received support from ANM/MPW/LHV/HA while working in the community. 36ASHAs (90%) stated that they had received support from the PHC/CHC in case of referring the patients. 32ASHAs (80%) responded that Block facilitator did visit them. **INCENTIVES:** An average incentive earned by an ASHA in last three months was found to be Rs.2199. 35ASHAs (87.5%) responded that they were not satisfied with the kind of incentives they receive. Only 20 ASHAs (50%) maintained record of the incentive they received for their job. 31ASHAs (77.5%) responded an irregular payment of the incentives from the authorities. 37ASHAs (92.5%) responded that they have joined the scheme purely for the financial reason, as to support their families. All the 40 ASHAs (100%) responded that if provided, they would like to have a fixed monthly salary. An average expected monthly salary by an ASHA worker was found to be Rs. 1680. 36ASHAs (90%) would like to continue working as an ASHA worker in future.

DISCUSSION

The average duration of working as an ASHA in Jawhar block was found to be 11.65 months. Although NRHM guideline states that the process of the selection of ASHA should be rigorous, involving various community groups, self-help groups and village health committees. But here no such procedures were found to be followed. Largely the ASHAs are identified and selected by ANM or MPW or LHV or HA or M.O. of the PHC. The Sarpanch's role was restricted to mere signing of the reference letters. The Community members were not even aware of the process. 15% of the ASHAs didn't not receive any appointment letter from the government. They were just informed verbally by AW or ANM or LHV or HA about their selection. These ASHAs didn't possess any documented evidence which is stated necessary for the working as an ASHA. Almost 97% of the ASHAs were not provided with any ID cards.

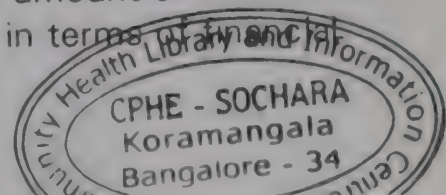
Due to some administrative problems, 12 ASHAs from sakur PHC had acquired double training (1st to 3rd module), both from NGO (BAIF-MITTRA) and Government trainers. Along with this they also received double training allowance and TA/DA. Although the Medical Officer had informed about this situation to the head office, still there was no action found to be taken. This shows a duplication of efforts and wastage of time and money. 13 ASHAs (32.5%) recollected incidences of absenteeism amongst other ASHAs during the training process.

The major causes of absenteeism were found to be reasons like remoteness of the villages and presence of small kids in the family. Due to hilly terrain many hamlets were found to have poor accessibility. As per guidelines, ASHAs should be provided facility to stay in the PHC during their training sessions. But these were not provided due to lack of infrastructure. Even situations were found like TA were provided once in seven days of the regular training process. Due to such infrastructural problems ASHAs daily travel from their hamlets to PHCs and have to bare the travelling expenses from their own pocket. The training given by the government trainer is not up to the mark. Trainer was not found to be enthusiastic and at times was found to be merely reading the text from the book, leaving aside the explanation part. 17 ASHAs were found to be absent during a day of training. 6-7 of them were found to have skipped the post-lunch sessions of training and the trainers were not even bothered of this. The trainer who was working as an HA in the PHC complained that he was overburdened with the multiple tasks. He expressed dissatisfaction in working as an ASHA trainer. The ASHAs who received training both from NGO and PHC reported a higher quality of NGO training compared to the PHC training. NGOs used methods like storytelling, role plays and recreational activities like games, songs which were not used by latter. They even provided accommodation facilities for the training process.

15% of the ASHAs were not provided any kits. They had to use plastic bags for this purpose. 75% ASHAs responded irregularities in supply of drugs. The ASHAs complained that M.O. of the PHC didn't pay any attention to this irregular supply of drugs. ASHAs didn't conduct any counseling activities and meetings in the community since, there was no training provided for the same. There were no on-the-job training provided by ANM or MPW to ASHAs. NGO trainer quoted that, 'ASHAs are merely for the purpose of holding the bags of ANM or MPW.' 75% ASHAs complained that they face problems while working in the community like, abuse from the community members as well as dai, inadequate attention paid to them and no proper compliance to treatments. The community members were not found to be sensitized about the ASHA scheme and roles and responsibilities of an ASHA worker. ASHAs didn't receive any reimbursement for the transport expenses of the patient to PHC or CHC. They also didn't receive any reimbursements from the Village health committee. Block facilitator (BF) who are entrusted with the responsibility of monitoring the ASHAs, restricted themselves to merely collection of their work records. There is no training been provided to BF for the purpose of proper monitoring of ASHAs. BF of jamsar PHC quoted that, 'an ASHA relatively possesses more knowledge than us since we are not been provided any sort of training.' For this sort of mechanical job of collecting work record a BF receives a monthly salary of Rs. 3000, whereas an ASHA who is main service provider, with multiple job responsibilities hardly able to receive an incentive of Rs. 1000 in a month. 87% of the ASHAs are dissatisfied with the kind of incentives they receive as 77% of the ASHAs responded of an irregular payments of incentives. Although many ASHAs had joined the scheme from Aug2007, they started receiving incentives only from Jan2008. 50% of the ASHA were found to be not maintaining any records of the incentives received by them. This is leading to job dissatisfaction amongst them.

ASHA states that referring cases for institutional deliveries provides them with maximum amount of incentives. Other referrals don't provide them satisfactory amount of income. In case if a community is small then becoming an ASHA is not feasible in terms of financial

PH-100
14022P09



implications. There are no incentives provided for certain activities like a daily visit to community, providing drugs, accompanying ANMs or MPWs.

Majority of the ASHAs belong to a very poor financial background. Subsistence farming is the main occupation of their families. The average annual income of their household was found to be Rs. 12,800. 92% of the ASHAs had joined the scheme to support the family financially. When asked 100% ASHAs responded that they would like to have a fixed amount of monthly salary. An average expected monthly salary by an ASHA worker was found to be Rs. 1680. Despite huge job dissatisfaction, 96% of the ASHAs still would like to continue as an ASHA in the hope that some day they would be absorbed as permanent employee in the health system.

ASHAs have tremendous potential and capacities which could strengthen the primary health care system. As information provided by MO of Sakur PHC that the number of institutional deliveries in year 2009(120) has doubled compared to year 2008(50) due to referrals by ASHAs. The need of the hour is nurture, support (emotionally and economically) and strengthens ASHAs. Improvement in Selection process, training sessions, active involvement of NGOs, strong support and monitoring system and fixed monthly salary could be the future options to strengthen the ASHA scheme.

This study has thus attempted to give insights of the ASHA scheme and hereby, states the need of large scale research studies in this area.

REFERENCES

1. Guideline for ASHA scheme, NRHM, <http://www.mohfw.nic.in/NRHM.htm>
2. Understanding Community Participation, Public Health Resource Network (PHRN), NHRSC, Chattisgarh.

Dr. Norboo Angchuk (norbooangchuk@yahoo.com)
Student [MHA-Health (2008-10)]

Chronic Mountain Sickness in Ladakh

INTRODUCTION

CHRONIC MOUNTAIN SICKNESS (CMS) IS A MALADAPTATION SYNDROME occurring in persons long residing at high altitude, characterized by erythrocytosis and hypoxemia (Monge and Whittembury, 1976) and by reversibility on descent. It may be classified as primary (without a cause) or secondary (due to underlying cause) (Leon-Velarde et al, 1998). This entity has been extensively studied in native Andeans (Leon-Velarde), Chinese – Tibetan (Ri-Li et al 2001) population but to our knowledge has not been studied in the Himalayan population. While studying cardio-pulmonary function in high altitude residents of Ladakh in 2003 (Wood and Norboo) we observed the CMS does occur in high altitude Himalayan population residing at an altitude of >4000 meters above sea level. The present study carried out in male residents of Korzok (4,550 m) in Ladakh was an attempt to look into the prevalence of CMS and characterize its feature in the light of CMS.

We studied a population of nomadic population living at an elevation of 4550 m about 240 km north east Leh, Ladakh, India at Korzok on the bank of Tsomoriri Lake. This unique live-stock rearing population having born hypoxic (birth altitude 4,550m) and having lived a hard hypoxic life are also deprived of fresh vegetables, fresh fruits (antioxidants) and better medical facilities. This area is free from all industrial pollution, smoking tobacco is limited to few men and unlike Indus valley belt in central Ladakh, non occupational pneumoconiosis has not been reported from this area. It was therefore postulated that Hypoxemia (low SPO₂) and excessive erythrocytosis observed in subjects at high altitude could be primary to hypoxic environment as such and not secondary to other underlying conditions . It occurred more in males and the criteria laid for CMS did not occur below 4000 m. We therefore confined our subjects to Korzok (4,550m)

METHOD AND DESIGN

We studied 91 male subjects all residents of korzok 4550 m, the demographic features are as under table 1

	Average	Std dev(+/-)
Age	42.24176	14.02327
BMI	23.44	3.12
SPO ₂	84.15	4.54
SBP	124.28	19.4
DBP	82.14	11.86
HR	75.94	12.33
GLU	97.56	20.51
Hct	51.76	7.11
Hb	17.42	2.18

Table 1:- Demographic features of the studied population of Korzok (alt 4,550m) (n = 91)

Criteria for inclusion were all men aged 18 years or older who were born at that altitude and who had not lived at low altitude for more than three months during the previous year. A detailed examination was done by the doctors with particular intent to rule out conditions leading to secondary CMS. Questionnaire of sign and symptoms designed by CMS scoring of international consensus group was administered by one of us. Dilation of veins in hands and feet (61%), cyanosis of lips and face (59%), dizziness (53%), injected conjunctivae (40%) and headache(34%) were the common features.

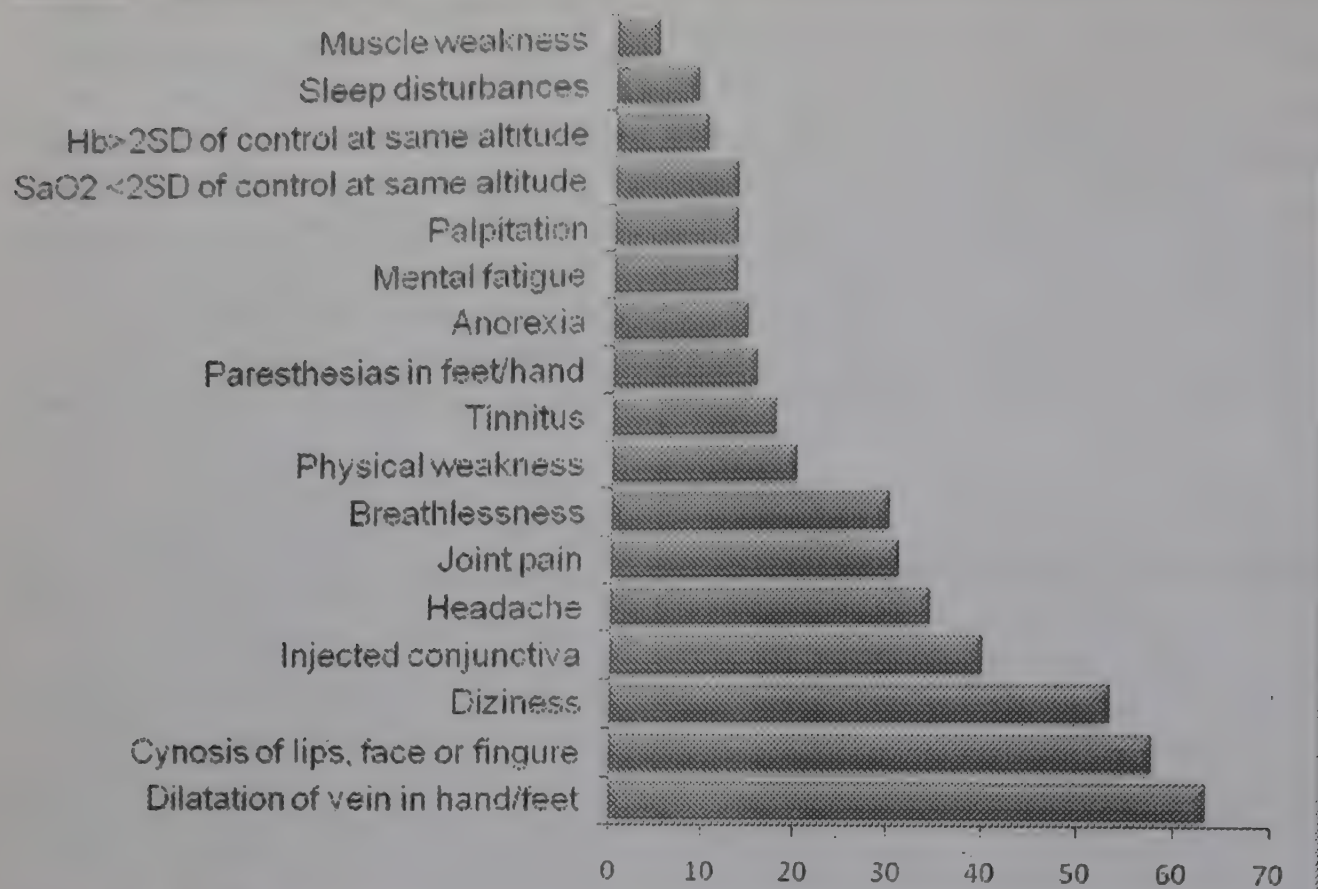


Figure -1: CMS symptoms and its relative prevalence in Korzok (4550m)

Height and weight are measured with the standard stadiometer with the beam balance and BMI calculated as weight in Kgs/height in meters square. Hemoglobin level was measured on blood obtained by venipuncture using a portable, battery powered photometer (hemocue AB, Sweden). The same instrument has been used by us in studying population in Nubra (2900m). SPO2 was measured with PULSE OX -M24 Tejin, which had been validated and the same instrument has been used in studying other population of Ladakh. Lactate in arterial blood as sample was analyzed with i-STAT portable clinical analyzer.

The mean Hb level of Ladakhi men at 3300m was 16.3(1.7)g/dl and Ladakhi men at 4,550 m was 18.0(2.1)g/dl measured during our previous study in 2003 and the SPO2 was 90.7(3)% and 85.5%(4.3) accordingly. In our recent study of 2006, we found the average Hb of Ladakhi men at 4,550m to be 17.46(2.18) g/dl and SPO2 to be 84 (9.5)% thus making Hb of 21.46 g/dl(> 2sd) and SPO2 of 79.5 (< 2SD) as cut off point for CMS scoring.

Using international consensus group CMS scoring, 2% of our subjects had severe, 7% moderate, 16% had mild CMS scoring. Blurring of vision and occasional diplopia, a symptom not included in the international consensus scoring were an unusual complaint reported by 10% of our subjects which needs specific study and explanation.

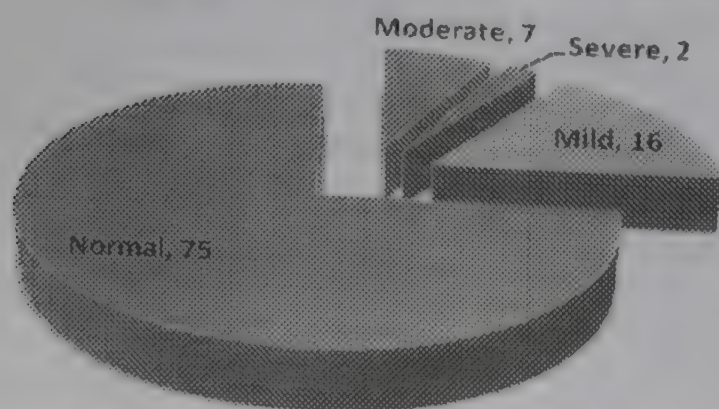


Figure 2:- Percentage distribution of studied population based on international CMS scoring .

We found an inverse relation between Hb concentration and SPO2 at Korzok (4550 mt).

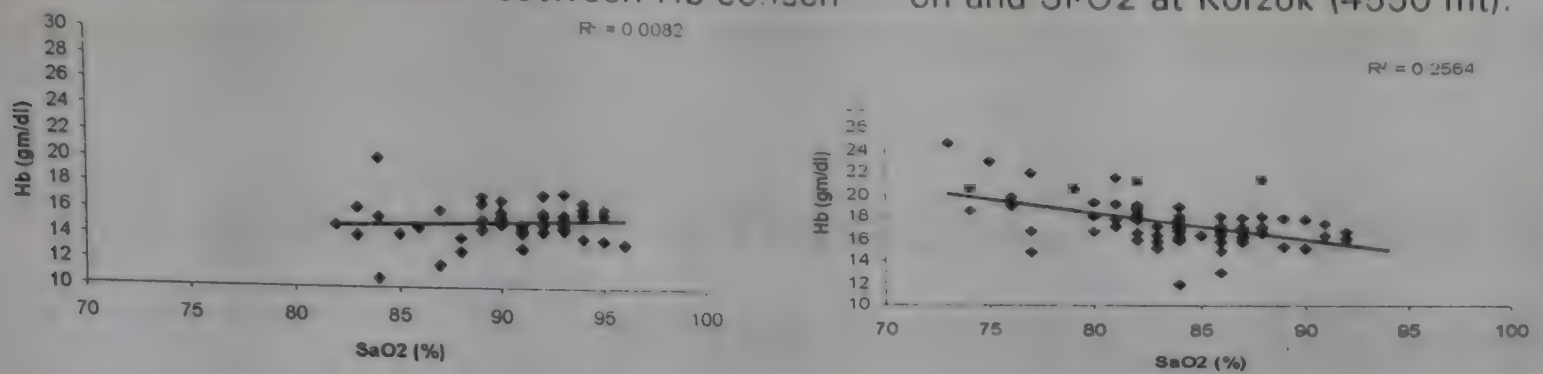


Figure 3:- Relationship of SpO2 and Hemoglobin Hb In Nubra 2900m (left) and Korzok4550m (right)

There was a rise in hemoglobin concentration with increase in age which can be attributed to one of factors of CMS (Sime et al). Such altitude related rise in Hb with age was not found in male subject residing at 2,900m above sea level (Figure 5).

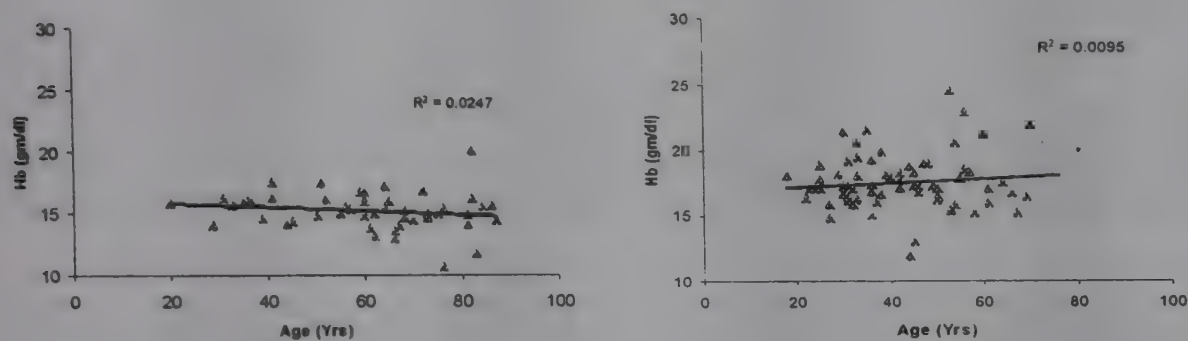


Figure 4:- Relationship of age to hemoglobin in Nubra 2,900m (left) and Korzok 4,550m (right)

Although at extreme altitude, the frequently termed lactate paradox (Hochahka et al) has remained controversial, but our result shows a direct correlation of blood lactate concentration with CMS.

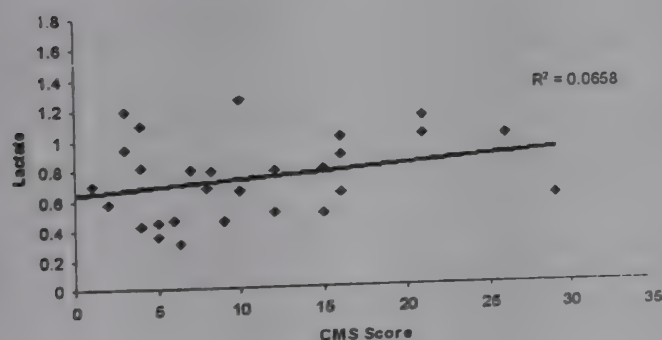


Figure 5:- Lactate v/s CMS scoring in the studied population at korzok(4550m)

CONCLUSION

As researchers in different parts of the world are trying to arrive at a consensus definition of this poorly understood syndrome of chronic mountain sickness, this paper which is the first of its kind on the subject from the Indian Himalayas may add up further information and may stimulate researchers to study in depth human adaptation to chronic hypoxia with rich prospects of application of the knowledge to sea level where Hypoxia is at the root to many common cardio-vascular, neurodegenerative and other disease.

Need For Capacity Building In Healthcare in India A Situational Analysis

INTRODUCTION

IN INDIA HEALTH IS NOT CONSIDERED AS a fundamental right, but considered as directive principle, i.e state's domain. The goal for every government is to improve health status and human development, which embraces equity, solidarity, social justice, human rights, and moral and ethical imperatives. The time has come to protect human rights as both the foundation of public health practice and the cornerstone of public policy actions. Right to health is nothing but a part of right to development. Since development is a continuous process, there is nothing called starting point and exit point. Development consists of infrastructural development, man power development, and development of the status to accept the services by the target beneficiaries.

Golden opportunity had been missed about six decade back when the Bhore committee report got a poor response from the country's then executives. If the Bhore report would have been executed properly, the country by that time could have had 567 hospitals beds, 62 doctors, 151 nurses per 100,000 populations. In 1988 these ratios were 76.3 beds, 42.9 doctors per 100,000 population (100 per 100,000 if we include non-allopaths), 28.7 nurses per 100,000 population(4). About three decades after the Bhore report, in year 1978, the Alma-ata conference again stressed upon the need for strengthening of primary health care. In 2008, WHO once again asks for a whole hearted drive for providing comprehensive health care at the community level.

Therefore, there is a continuous need for a sustainable mechanism to meet the health care needs of the poor in India. The objective is to increase access of poor individuals and families to quality health care at an affordable cost and ensure equity. We can broadly label them as capacity building in the sector of infrastructure development, human resource development including man power training, and capacity formation (financing mechanism) for the poor to accept or buy the health care services at a price which society and country can afford. Objective of this article is not to assess the amount of requirement but only an effort to have a look into the situation in the areas of capacity within the system.

SCENARIO OF INFRASTRUCTURE

The existing public health infrastructure is far from satisfactory. For the OPD facilities, funding is generally poor, the presence of doctors and para-medical personnel is often much less. The availability of consumables is negligible, the equipment in many government hospitals is often unusable, the buildings are in a dilapidated state. In the IPD facilities, the equipment is often obsolescent; the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate. It leads to over-crowding, and consequentially to a steep deterioration in the quality of the services. As a result of such inadequate public health facilities, it has been estimated that less than 20 percent of the population seek OPD services, and less than 45 percent seek indoor treatment in government hospitals(1).

This is despite the fact that most of these patients do not have the means to make out-of-pocket payments for private health services. The patients have little scope for diagnostic services. There is little incentive for the beneficiaries to seek the advice of the doctors in the public health system. This results in having no demand for medical services, so doctors and paramedics often absent themselves from their place of duty.

The number of SC/PHC/CHC has increased 3 fold, beds (private and public) have increased by 1.5 times in the year 2000 compared to the 1981(1). But there is considerable inequity across the states and it has in fact increased. Total vaccination status² has become 43.5% (as per NFHS-3, compared to 42% of NFHS-2). Only 23% of the newborns were offered exclusive breast feeding within 1 hour of birth (compared to 17% as per NFHS-2)(3). These figures are far from encouraging.

SCENARIO OF MANPOWER

Today there are several PG programmes in public health education in India. Many of these programmes aim to produce a public health workforce at the professional level. Public health professionals are those who are able to effectively undertake the development and management of public health programmes. Public health programmes are involved particularly in areas such as maternal and child health, disease prevention and control, nutrition, and environmental health, including water and sanitation. It is indeed a commendable task for the Government of India to ensure the presence of an adequate number of such professionals in the public health workforce. Public health is a combination of several disciplines e.g epidemiology, bio-statistics, laboratory sciences, social sciences, demography etc and requires diverse skills like epidemiological investigations, surveillance and response, evaluation etc and several categories of professionals are involved in the delivery of public health. Establishing and sustaining an effective public health workforce in India to achieve national health goals cum MDGs will require good policy to be translated through an effective strategy and implementation with mechanism of monitoring and periodic evaluation.

The number of medical colleges increased from 150 in 1995 to 262 in 2005(2). The State of Maharashtra used to produce about 1/5 th of the total medical graduates in the country, but about 1/4th of the seats of PHC doctors were vacant in year 1995(2). In India, 75% - 80% of medical colleges are government subsidized, exports the most number of doctors to the developed countries. The U.S. alone has over 50,000 doctors from India. There is one Indian doctor available for every 1,325 Americans; while in India there is one Indian doctor for every 2,400 Indians. Approximately 30% of doctors in the UK NHS are Indian doctors(6). In the first decade after establishment about 60% of the pass-outs from AIIMS had left the country. It is not a surprising fact that community health centres in rural areas in India are understaffed by over 50% in terms of doctors(6). The estimated shortage of health workers is considered around 20% (considering WHO standard of 25 per/10,000), in India which could be around 0.4-0.6 million. Density of the health workforce (per 10,000 population) across the states in India, ranges from 23.17 in Chandigarh to 2.51 in Meghalaya. There are no super specialty courses in public health in the medical colleges among 649 DM/MCH seats. For about 15000 medical graduates every year, about 9000 PG degree seats in Medical colleges/ institutes 368 (3.95%) are for PSM and community health administration. For various diploma courses numbering 3466 in the country 161 (4.65%) are for public health. Now every year about 560 physicians (degree /diploma together) complete postgraduate training in community medicine. Most of them work as community medicine faculty in medical colleges and a few of them get absorbed in medical research institutions and a large part particularly the diploma ones join health services and a few join international organizations. International organizations such as WHO, UNICEF, World Bank etc. prefer to employ PSM specialists but our own central and state government health services have not created sufficient job opportunities for them(7)

Among other category of public health work forces, certain categories of health workers, such as physiotherapists, medical technicians and faith healers, are not recorded in government statistics, making it difficult to assess the overall size and composition of the health workforce. According to the NFHS-3 data about 17% of Indians have reportedly have not met a health worker over a period of 3 months. So far the usage is considered, only 67.4 and 32.4 % of urban and rural mothers respectively have used a health centre for their last child birth(1). Currently about 67% of the post of specialist doctor, 50% of lab technician, 40% nurses, and 15 % of multipurpose workers post are remaining vacant. However the number of doctors has increased 1.5 times and number of nurses about 5 times in the year 2000 compared to 1981(1).

We are in the Health Workforce Decade (2006-2015) as announced by the WHO and Human Resources for Health have been discussed as a key theme in the World Health Report, 2006, titled: 'Working Together for Health'. Observations based on the 2001 Census and the NSSO surveys indicate that health workforce density (doctors, nurses and midwives) in India is below the 2.5/1000 population benchmark, though there is considerable inter-state variation(6).

This becomes particularly important as the Government seeks to increase the availability of health services in underserved areas through the NRHM. This effort should not just focus on increasing the production of health workers but, offer the right amount of incentives, including salaries. Medical students prefer to concentrate on their post-graduate education and are not inclined to work in rural areas while nursing students have a greater inclination to work in public settings. Recruiting and retaining doctors to serve in facilities of rural areas is difficult given both the physical conditions in those areas and the expectations and attitudes of new medical graduates. The Government of India has increased its financial allocation to health through the NRHM and the new Indian Public Health Standard (IPHS) – norms for health facilities that, to be achieved, will require many more doctors to enter public health service. Poor retention of public health workforce is a problem in most of the developing countries.

SCENARIO OF HEALTH EXPENDITURE & STATUS OF FINANCING

In a developing country like India high levels of private health expenditures can be a serious challenge to national economic development. About 76 per cent of the healthcare expenditure is out-of-pocket in India. These expenditures as proportion of per capita income have almost doubled since 1961. This was 2.71 per cent during 1961-70 and increased to 5.53 per cent during 2001-03. During the period 1991-2003 private out-of-pocket expenditures on health has grown at 10.88 per cent per annum whereas per capita income has grown at 3.76 per cent during the same period. The size of these expenditures poses problems for families who have no ability to pay, compelling them to fall into the unethical money lender's trap and suffer further. It has been also indicated that on an average, population in the poorest quintile are 2.6 times more likely than the richest to forego medical treatment when ill due to financial reasons.

India currently spends about 6 % [4.7% is from private, of which 4.5% is out of pocket, and 1.3% is public spending] of its GDP on health care(WDR'93). This comes to USD 23/Rs 1,021 per capita(MOH & FW'2001-02). Despite such a high share of expenditure by individuals, the provision of health care in terms of quality and access is not satisfactory. According to an estimate, one-quarter of all Indians become impoverished as a direct result of medical expenses during hospitalization. Studies have shown that more than 40% of hospitalised Indians have to borrow or sell assets to meet hospitalisation expenses. Often they pay very high interest rates for that. This causes a rise of about 2% of poor population per year(8). In India less than about 5% of the population are protected by any kind of health insurance,

of which about 26 and 20% are being provided by the ESIS and CGHS respectively. Another 17% people have any kind protection by the employer provided medical reimbursement scheme. However the largest of all, about 27% people are protected by any privately purchased health insurance products. Community based health insurance is only 5%(5).

VIEWING THE SCENARIO

Public private partnership (PPP) has become a way to solve the infrastructure related issues. Only few of them have been properly followed by any mechanism including cost-effective analysis to determine whether they are really cost effective or not. Well laid plans to satisfy the common objectives of both/all the partners in a PPP is essential for its long run success.

While developing a public health workforce it needs to be understood that public health work requires "multidisciplinary and multispectral" action. This is even more important in areas of health promotion and health protection as well as disease prevention and control in the community. Therefore, the opportunity for public health education and training should also be extended to several related disciplines and to staff of other sectors. Social orientation is to be given priority during the process of recruitment of the faculties. Opportunities must be provided to them to attain experience on the community health.

In the light of the Fiscal crisis facing the government at both the central and state levels, the shrinking public health budget, the escalating health care costs coupled with demand for health care services and lack of easy access to quality health care for people from the low income group to quality health care, Health insurance is emerging as an alternative mechanism for financing health care, specially the community based health insurance. Presently the penetration of community Health Insurance is very limited – just about 5 % of the population having any health insurance. There is a need to explore the mechanism to protect the population with a health insurance mechanism so that they pay a small amount when healthy and are protected from high medical costs at the time of illness. Need identification and finding a credible and trustworthy and registered NGO, CBO, corporate society or micro finance organization that is familiar to local community is the key to the formation of a sustainable health financing mechanism for the poor of the country.

REFERENCES

1. The National Health Policy document 2002.
2. The Medical Education Policy document
3. The National Family Health Survey(NFHS-3),2005-06,India,Volume 1
4. Resurrecting Bhore-Ravi Duggal (MFC Bulletin, No. 188-9, November-December 1992, pp 1-6)
5. Health Insurance in India-National commission on Macroeconomics and Health, Govt. Of India
6. Health Worker Migration Initiative-Kushal , a online e-news letter of the Public Health Foundation Of India-Issue 1/Aug 2009
7. Public Health Workforce In India: Career Pathways For Public Health Personnel-Dr K K Datta-2009
8. Planning And Implementing Health Insurance Programmes In India-An Operational Guide-Dr N Devadasan And Mr Sunil Nandraj-IIPH,Bangalore,May2006

Malaria for All: Experiences from Orissa

ORISSA'S NUAPADA, KEONJHAR AND MALANGIRI DISTRICTS have seen all the four types of Malaria, i.e. *Plasmodium vivax*, *Plasmodium falciparum*, *Plasmodium ovale*, *Plasmodium malariae*. Because of the favourable and conducive environment, the parasite and the vector population sustain well in these regions. Although the population of Orissa state represents only 4 percent of the total population of India, it contributes 22 percent of all malaria cases, 43 percent of all cases of *Plasmodium falciparum* malaria and 50 percent of all malaria deaths reported in the country.

The condition of Malaria Control Programme is pathetic like never before even after the intervention of NRHM in tandem with NVBDCP. If an individual living in a village develops fever, it will take at least 3 days for the local health worker to come and collect the blood for malaria test (there are often huge distances involved). He will send this slide to the Community Health Center (CHC) only on Saturday, the day when they have sector meeting. Suppose the day when he collected the slide is a Sunday, by the time the slide reaches the testing lab, there is a delay of 10 days. On Saturday, when these health workers dump all these slides collected from different sectors in the CHC's laboratories, the lab technician cannot examine them in the same day, howsoever sincere he/she may be. It is humanly impossible as the technician is already overburdened with the CHC's own work load. So the technician will take another 3 or 4 days to see all these slides. Many of them write the report arbitrarily without looking into the slides. If you question them, they will say that they have an intuition recognising the parasites! Further, the health workers cannot take reports till next Saturday, as they go only on Saturday to C.H.C. It will take another 3 days for the health worker to locate the person and give the report with scientific medicines.

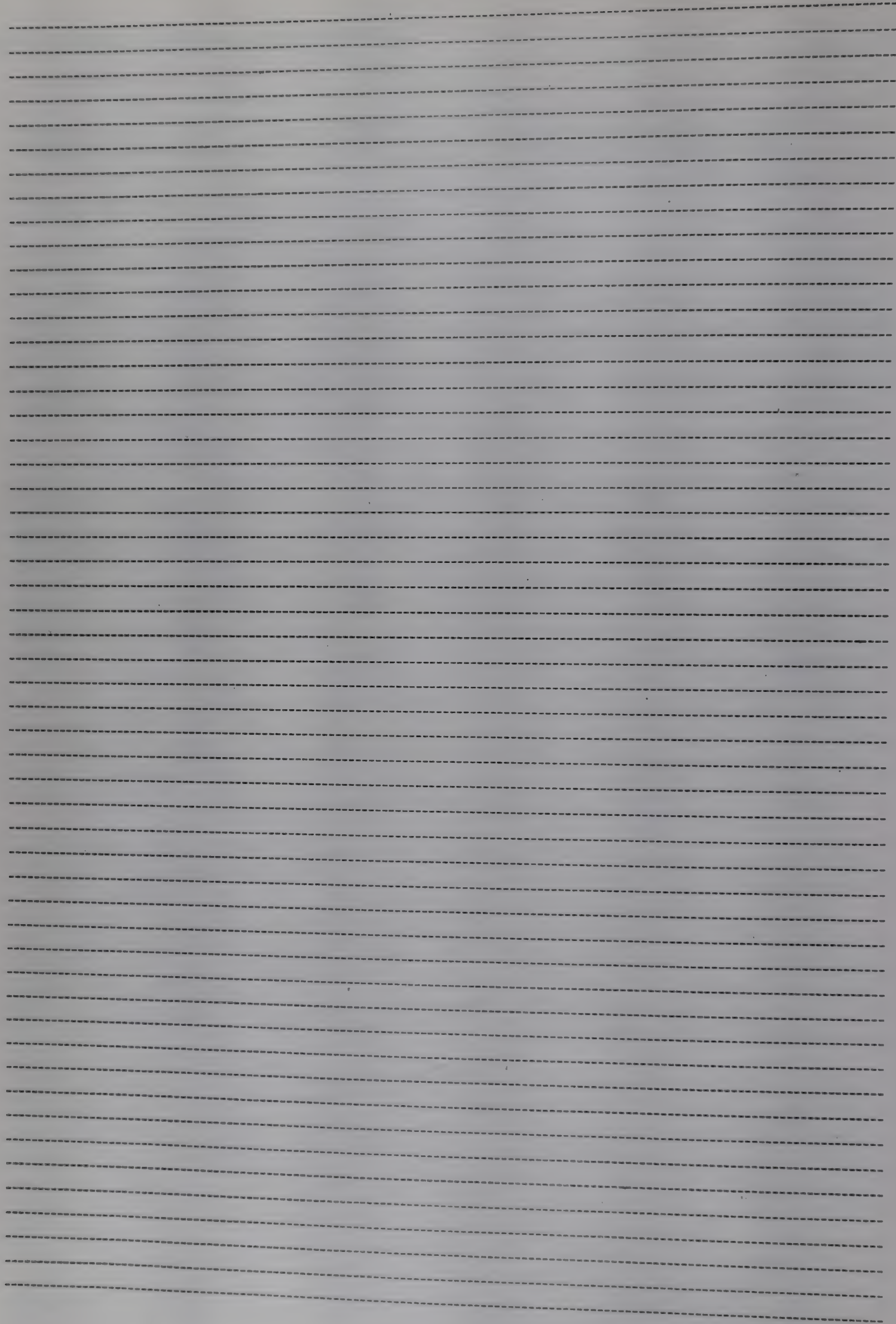
That means a gap of around 21 days before the affected person gets the proper treatment. This not only affects the individual, but also allows the mosquito to take the parasite from the affected person and spread it to others. There have been cases where a gap of six months was seen between the onset of fever and the availability of report. This is the situation of malaria control programme in the country's severely affected State. But every time the government has a justifiable answer. When somebody raised this question they say, "What happened if we take 21 days to diagnose the disease? We are giving the presumptive treatment of malaria from day one itself. And by that we have decreased the mortality rate of malaria."

It is true that presumptive treatment with 10 tablets of Chloroquine for 3 days along with 45mgs of Primaquine on day one (for adult) is being given, but this is actually the treatment for *Plasmodium falciparum* which is being given on benefits of doubt because this species may cause complications like cerebral malaria. But had it been a case of *Plasmodium vivax*, instead of giving Primaquine 15mgs per day for 14 consecutive days, only 45mgs would have been given for one day. Of course, the mortality rate may be reduced by curing *falciparum* cases but the morbidity will increase due to relapse of *vivax* cases as the complete dosage is given only very lately, if at all. This is one of the reasons for development of resistant malaria due to the indiscriminate use of Chloroquine. Now Arteether and Artesunate are being used as second line treatment for malaria. But there are high chances of development of resistance if treatment goes in this way.

The need of the hour is to diagnose the fever on the spot. Government has provided Rapid Diagnostic Kits (RDKs) to every ASHA in the village. They could diagnose every P.F.R or P.V cases, that too at no cost to the beneficiaries. Govt has also supplied these Kits along with training materials to C.H.C. But due to lack of proper training & capacity building, they are unable to perform it. In some places, the administration knowingly doesn't co-operate as this might hamper their private practices.

At the cost of Village Health Guides, Government had created posts of Malaria Supervisors, one in every 2 or 3 blocks. Of course they do some good paper works but those VHGs were more close to people. It is a known fact that malaria occurs due to stagnation of water and damp surrounding. But Govt's policy is not to clean up that water body. Instead, they give larvicidal fish (Gambusia) to keep in such cesspools. D.D.T and Cyper Methrine are used for spraying. Instead of fighting malaria through good sanitation or better health awareness, they distribute (as the World Bank advises) bed nets "impregnated with anti-mosquito repellent", Gambusia fishes, D.D.T, etc. That way, there's technology, contracts, and rewards for corporate, consultants, and corrupt bureaucrats.

Many have pointed out that there is always fault in implementation. But, it appears to be "the best implementation of the worst policies." For instance, in the 1992-93 budget, the union government slashed the national Malaria Eradication Programme's funds by nearly 43%. Other health programmes suffered too. In the same budget, the top 10 % of the population got tax concessions worth Rs. 4,800 crores. This was of a piece with the "trickle-down theory". Take it away from the poor, give it to the rich and then watch with bated breath to see how much of it trickles down to the poor. What trickled up was money, what trickled down was malaria.



With best compliments to our TISSians from,

niche
health options

SURROGACY India



making babies possible

A niche healthcare initiative, managed by a proficient doctor & a yearning TISSian.

Unique Model:

- Zero investment initiative.
- Pioneering new arenas in Indian healthcare sector.
- Crossing more that 100 client cycles & revenue over INR 100 million in 2 nd year of operation.

Our Focus & Learning:

- Customer focus – complete umbrella cover.
- Service excellence.
- Outsourcing to the best.
- High emotional quotient.
- Innovation at every step.

Dr Yashodhara Mhatre
Director, Fertility Physician

Dr Sudhir Ajja
Founder, Managing Director

E-mail : : possible@surrogacyindia.com Website : www.surrogacyindia.com

109 R R Realty, opp Dream Mall, off. L B S Marg,
Bhandup West, Mumbai-400 078, India.



TATA INSTITUTE OF SOCIAL SCIENCES

School of Health Systems Studies

Presents

CLAIRVOYANCE 2009

Building Capacities in Health Care

Enhancing abilities, mitigating vulnerabilities

Date : 19th - 20th December 2009

Venue : Convention Centre, Naoroji Campus
Tata Institute of Social Sciences
Mumbai- 400088

Official Media Partner :



E|X|P|R|E|S|S

Healthcare

INSIGHT INTO THE BUSINESS OF HEALTHCARE

Clairvoyance 2009 is an exploration of innovative ways to build capacities at various levels of healthcare. This year's event would comprise of a symphony of seminars, debates, and panel discussions highlighting newer approaches to various contemporary issues.

SPECIAL ATTRACTION FOR STUDENTS :

ANTERPRERNA
Health Model Competition

POLEMIC
The Debate

Attractive Prizes to be Won

"Envision the potential of Indian Healthcare at Clairvoyance."

Contact : 96194 84532 / 33; clairvoyance09@gmail.com Website : www.shss.tiss.edu

Clairvoyance 2009

TATA INSTITUTE OF SOCIAL SCIENCES, MUMBAI
School of Health Systems Studies
in association with
National Rural Health Mission Maharashtra
Presents

Anterprerana

The Entrepreneurship Competition...

Clairvoyance occupies the place of pride for School of Health Systems Studies. The event is dynamic exchange of knowledge and innovations towards betterment of health of the society.

Anterprerana is a platform for the entrepreneurs to express innovative ideas for providing healthcare to the unreached and remote parts of nation. Here is a call to stand up to the challenge to organize resources in new and more valuable ways to deliver healthcare

Theme for this years competition

"Innovative Health Care Delivery Models"

Plans / Models should be submitted as per the Competition guidelines available on our website :

<http://www.shss.tiss.edu>

For any queries please contact the Anterprerana Coordinators:

Dr. Amar Nawkar - +91 - 99308 95598

Dr. Amit Bhavsar - +91 - 94044 90797

Submit your proposals before 12th December 2009

Prize worth Rs. 25,000/- to be won!!

on

anterprena09@gmail.com

From Ideas to
"EXPRESSIONS"
for Better Health

A competition to encourage young talent
in the field of Health Communication

THEME: "Effective Media Interventions for Tobacco Control"

CONTENT OF ENTRIES: Slogan, Poster, Video Clips, Audio Clips etc.(visit website for rules and regulations).

ELIGIBILITY: Students pursuing media studies,
mass communication, public health and allied fields.

LAST DATE OF SUBMISSION: 17th December 2009 by 5.00 pm

PLACE OF SUBMISSION: The Secretariat,
c/o. Expressions,
School of Health Systems Studies,
Tata Institute of Social Sciences,
Deonar, Mumbai - 400 088.

ENTRIES ALSO ACCEPTED BY EMAIL AT: competition.expressions@gmail.com

FOR DETAILS CONTACT

Dr. Nikita Surani (+91-9833511180)

ORGANIZED BY

School of Health Systems Studies,
Tata Institute of Social Sciences, Mumbai.
Part of the International "Expressions09"

www.tiss.edu

POLEMIC

THE ANNUAL DEBATE COMPETITION
OF SCHOOL OF HEALTH SYSTEMS STUDIES
(TATA INSTITUTE OF SOCIAL SCIENCES)

STATE OF HEALTHCARE IN INDIA : WHO IS RESPONSIBLE ?? HEALTHCARE PROVIDERS OR SEEKERS

In the health care sector fixing responsibility has always been highly ambiguous. Who's the architect of the health status of a community? The health care providers who claim of constant efforts on their part or the seeker who's yet to discover enough reasons to appreciate those efforts.

Lets ponder...brainstrom.. raise some questions... get some answers.

Entire invited....

ATTRACTIVE PRIZES TO BE WON

PRELIM ROUND : Send in a write up of 500 words maximum expressing your stand (FOR/AGAINST)

Main Your Entries To : **polemic.shss@gmail.com**

Hard copy of the write up can be sent to
polemic

c/o Secretariat, School Of Health Systems Studies
Tata Institute Of Social Science

Last date for entries : 14th Dec, 12 pm.

For details contact:

Dr. Jaya Khushalani (98333 20014) Dr. Sachin Date (932243 90201) Dr Priyanka Nagdeo (98206 553459)



MHA (HEALTH)



MPH



MHA (HOSPITAL)

OUR SUPPORTERS



Science & Innovation
Network



ग्रामीण आरोग्य अभियान
महाराष्ट्र

HOSMAC

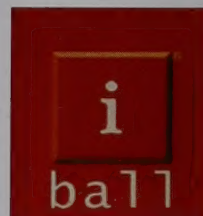
PERFECTING HEALTHCARE



FUSION[®]

Technology Partner

NARCO



TRIVECTOR

TRANSASIA[®]

UNIVERSITY OF MINNESOTA

School of Public Health



Vaatsalya



E|X|P|R|E|S|S

Healthcare

INSIGHT INTO THE BUSINESS OF HEALTHCARE

Official Media Partner

With Special Thanks to

TATA BUSINESS SUPPORT SERVICES

MHA BATCH (2007-2009)

